Doctors Medical Center Management Authority, JPA Board Meeting

Wednesday, October 28, 2009
3:00 PM - Auditorium
Doctors Medical Center
2000 Vale Road
San Pablo, CA

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY

Doctors Medical Center Management Authority,
JPA Board
Wednesday, October 28, 2009 – 3:00 pm
Doctors Medical Center - Auditorium
2000 Vale Road, San Pablo, CA 94806

Governing Board
Supervisor John Gioia, Chair
Sharon Drager, M.D.
Pat Godley
Supervisor Gayle B. Uilkema
Bill Walker, M.D.
Beverly Wallace
Eric Zell

AGENDA

1. Call to Order and Roll Call

2. Approve Minutes of Board Meeting of September 23, 2009

3. Public Comment
   [At this time persons in the audience may speak on any items not on the Agenda which are within the jurisdiction of the Doctors Medical Center Management Authority.]

4. Presentation and Acceptance of the September 2009 Financial Statements

5. Recommend approval of Outpatient Center Project to District Board:
   - *Lease space at San Pablo Town Center*
   - *Sublease space at San Pablo Town Center*
   - *Tenant improvement*
   - *Construction documents and equipment costs*

6. Approval of Resolution
   - *Maintain current wages for non-represented employees during the next fiscal year*

7. Joint Commission Report

8. CEO and Quality Report

9. Institute for Healthcare Improvement
   – *The Role of the Board in Quality and Safety Update*

Closed Session

Conference with Labor Negotiators (pursuant to Government Code Section 554957.6)
Agency Negotiators: Charm Patton, Vice President of Human Resources
Employee Organizations: California Nurse Association, Local 1.

10. Return to Open Session

Open Session

11. Report of Reportable Action(s) Taken During Closed Session, if any.

12. *Adjournment*

Minutes – 9/23/09

Tab2

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY

Doctors Medical Center Management Authority
Governing Board Meeting
September 23, 2009 – 3:00 pm
Doctors Medical Center - Auditorium
2000 Vale Road, San Pablo, CA 94806

Governing Board
Supervisor John Gioia, Chair
Sharon Drager, M.D.
Pat Godley
Supervisor Gayle B. Uilkema
Bill Walker, M.D.
Beverly Wallace
Eric Zell

Minutes

1. **Call to Order and Roll Call – 3:05 p.m.**

   Quorum was established; roll was called.

Voting Members:	*Supervisor John Gioia, Chair* *Eric Zell* *Beverly Wallace* *Sharon Drager, M.D.* *Pat Godley*
Absent:	*Supervisor Gayle B. Uilkema*

2. **Approval Minutes of Board Meeting of August 26, 2009**

   The motion made by Mr. Zell and seconded by Ms. Wallace to approve the minutes of the August 26, 2009 Board meeting was passed unanimously.

3. **Public Comment**

   There were no public comments.

4. **Presentation and Acceptance of August 2009 Financial Statements**

   Richard Reid, CFO, reported August 2009 net income was a gain of $259,000 on a budget of $53,000; the average length of stay increased to 5.2 days and the average daily census was 83. He reported that the total cash balance is $10.5 million and there are 28 days of cash on hand.

   The motion made by Mr. Godley and seconded by Dr. Drager to accept the financials for August 2009 passed unanimously.

5. **Approval of Capital Expenditure**

   a. Reconditioned Beds

      David Ziolkowski, COO, sought approval to execute on behalf of Doctors Medical Center (DMC), an agreement with Hill-Rom to purchase 25 acute care beds, 10 ICU

beds, 25 over-bed tables and 25 bedside cabinets. This expenditure is being funded through the Capital Budget, which was approved in 2009 with a fiscal impact of $233,520.78.

The motion made by Supervisor Gioia and seconded by Dr. Drager to approve and authorize David Ziolkowski, COO, to execute on behalf of Doctors Medical Center an *agreement with Hill-Rom to purchase 25 acute care beds, 10 ICU beds, 25 over-bed tables and 25 bedside cabinets passed unanimously.*

b. New CT Scanner

David Ziolkowski, COO, sought approval to execute on behalf of Doctors Medical Center (DMC), purchase of a new CT Scanner from Toshiba and radiology software from McKesson. This expenditure is being funded through the Capital Budget, which was approved in 2009 with a fiscal impact of $1, 350,000.

Dr. Evans, Director of the Radiology Department, gave a power point presentation showing the difference in the capability of this new CT Scanner.

The motion made by Ms. Wallace and seconded by Dr. Dragger to approve and authorize David Ziolkowski, COO, to execute on behalf of Doctors Medical Center Purchase of a new CT Scanner from Toshiba and radiology software from McKesson passed unanimously.

6. **Discussion and action on establishing a policy that maintains current wages for non-represented employees during the next fiscal year**

As was discussed in previous meetings, DMC is losing three major funding: State/Federal Monies; Kaiser & John Muir, and in preparation to this, management is seeking direction from the Board in the establishment of a policy that will maintain current wages for non-represented employees during the next fiscal year. Supervisor Gioia indicated that this policy will not affect negotiations with the Unions and regular step increases for employees.

Supervisor Gioia made a motion giving direction to management to draft a JPA policy and their intention not to have salary increases to non-represented employees during the next fiscal year. Mr. Zell seconded it. The motion passed unanimously.

The policy will be brought back at the October JPA meeting.

7. **CEO and Quality Report – Joseph Stewart, President/CEO**

- Mr. Stewart reported that the Joint Commission was here last week for a three-day survey of our Laboratory as part of the overall survey. The Laboratory, he stated, passed with flying colors. The deficiencies that were cited are as follows:

- Proficiency test deficiency
- Clerical transcription error
- Monitoring of temperatures – manual vs. automatic

Plans of correction were submitted to correct these deficiencies.

- DMC was admitted to two national collaboratives with the Institute for Healthcare Improvement:

  - Reduction of readmission to hospital within 30 days of discharge. Eight hospitals were invited to participate. Because of the County, we were invited to participate.
  - Transformation of care at bedside (TCAB).

- Mr. Stewart reported a major transformation of the nursing shift to 8 hours. He explained that the nurses themselves voted on this. The schedule is completed and will become effective as of October 18, 2009 at 7 a.m.

- Mary Jo Sullivan, VP of Nursing, started a program with new graduates to start their rotations at Doctors Medical Center.

- DMC is about 90% completed with Joint Commission readiness based on the last mock survey held. Verge is used as part of daily compliance monitoring.

- DMC started a Tracer Program whereby a patient is picked randomly and follows the patient all throughout the services received here at DMC.

- With the opening of the Kaiser Cancer Center in Oakland, DMC lost patients but the addition of the IMRT, DMC's Cancer Center continues to meet and exceed their budget.

8. **Adjourn to Closed Session**

The JPA Board adjourned to closed session at 4:05 p.m. Supervisor Gioia announced that there would be no reportable actions that will be taken during the closed session.

Financial Statements September 2009

Tab 4

DOCTORS MEDICAL CENTER

September 2009 Executive Report

Doctors Medical Center had a Net Income of $46,000 in the month of September. As a result, net income was over budget by $33,000 due to higher net patient service revenue less higher salaries, professional fees, and purchased services.

Net Income was $46,000 over budget. The following are the factors leading to the Net Income variance:

Net Income Factors	**Over / (Under)**
Net Patient Revenue	
Billing Project	$373,000
Outpatient Volume variance	$382,000
Rate Variance	$108,000
2008 Medicare Cost Report	$440,000
Inpatient Volume Variance	($832,000)
Expenses	
Salaries	($198,000)
Professional Fees	($143,000)
Purchased Services	($90,000)

Net Revenue was over budget by $471,000. The efforts of the prior year billing project added $373,000 in net revenue. Outpatient volume exceeded budget by 6% resulting in $382,000 of additional net revenue. Our reimbursement amount exceeded the budgeted reimbursement levels by $108,000. DMC hired a consulting firm to assist with Medicare cost report issues. Because of the work done on the 2008 cost report, net revenue was increased by $440,000. Inpatient discharges was at budget but the payer mix was not. Managed care volume was under budget by 17, CDCR was under budget by 7 cases while self pay exceeded budget by 28. This payer shift resulted in a loss of reimbursement of $832,000.

Salaries exceeded budget by $199,000. This variance is down from the August variance of $457,000. The largest component of the variance is Outpatient volume at $123,000. Patient Accounting salaries exceeded budget by $33,000 related to the prior year billing project; additional EVS workers was $21,000. The nursing units are staffing at the required levels in compliance with Title 22.

Professional fees exceeded budget by $143,000. The variance consists of 4.5 interim staff at a cost of $101,000. The 4.5 interim staff are; 1 in Engineering, 1 in Sleep Lab, and 2.5 in Quality. Of the 4.5 positions, 1 will be replaced with an employee saving approximately $60,000. Legal fees in related to the various negotiations of $41,000.

Purchased services were over budget by $90,000. $68,000 related to PET program were unbudgeted as were the revenues from the program.

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
BALANCE SHEET
September 30, 2009
(Amounts in $1,000)

		Current Month	Dec. 31, 2008
	ASSETS		
1	Cash	2,340	7,218
2	Net Patient Accounts Receivable	15,350	8,647
3	Other Receivables	10,211	5,125
4	Inventory	1,860	1,886
5	Prepaid Expenses and Deposits	870	993
6	**TOTAL CURRENT ASSETS**	**30,631**	**23,869**
7	**Assets With Limited Use**	**5,517**	**8,566**
	Property Plant & Equipment		
8	Land	12,090	12,090
9	Bldg/Leasehold Improvements	34,287	33,304
10	Capital Leases	10,926	10,926
11	Equipment	32,251	30,651
12	CIP	755	642
13	Total Property, Plant & Equipment	90,309	87,613
14	Accumulated Depreciation	-46,654	-44,295
15	**Net Property, Plant & Equipment**	**43,655**	**43,318**
16	**Intangible Assets**	**596**	**627**
17	**Total Assets**	**80,399**	**76,380**
18	Current Ratio (CA/CL)	***1.06***	***0.99***
19	Net Working Capital (CA-CL)	***1,732***	***(265)***
20	Long Term Debt Ratio (LTD/TA)	***0.32***	***0.38***
21	Long Term Debt to Capital (LTD/(LTD+TE)	***0.53***	***0.66***
22	Financial Leverage (TA/TE)	***3.5***	***5.2***
23	Quick Ratio	**0.61**	**0.66**
24	Cash Days	**6**	**19**
25	Net A/R Days	**47**	**25**

		Current Month	Dec. 31, 2008
	LIABILITIES		
26	Current Maturities of Debt Borrowings	3,612	3,526
27	Accounts Payable and Accrued Expenses	10,797	8,672
28	Accrued Payroll and Related Liabilities	8,061	8,110
29	Deferred District Tax Revenue	3,385	3,180
30	Estimated Third Party Payor Settlements	3,044	646
31	**Total Current Liabilities**	**28,899**	**24,134**
	Other Liabilities		
32	Other Deferred Liabilities	490	3,327
33	Chapter 9 Bankruptcy	2,062	5,148
	Long Term Debt		
34	Notes Payable - Secured	25,496	27,858
35	Capital Leases	3,871	4,632
36	Less Current Portion LTD	-3,612	-3,526
37	**Total Long Term Debt**	**25,755**	**28,964**
38	**Total Liabilities**	**57,206**	**61,573**
	EQUITY		
39	Retained Earnings	14,807	-3,271
40	Year to Date Profit / (Loss)	8,386	18,078
41	**Total Equity**	**23,193**	**14,807**
42	**Total Liabilities & Equity**	**80,399**	**76,380**

WEST CONTRA COSTA HEALTHCARE DISTRICT
DOCTORS MEDICAL CENTER
INCOME STATEMENT
September 30, 2009
(Amounts in Thousands)

	CURRENT PERIOD				PRIOR YEAR		CURRENT YTD				PRIOR YEAR
	ACTUAL	BUDGET	VAR	VAR %	ACTUAL		ACTUAL	BUDGET	VAR	VAR %	ACTUAL
						OPERATING REVENUE					
43	10,651	10,180	471	4.6%	10,075	Net Patient Service Revenue	105,290	103,252	2,038	2.0%	99,981
44	107	81	26	32.1%	84	Other Revenue	782	723	59	8.2%	800
45	10,758	10,261	497	4.8%	10,159	**Total Operating Revenue**	106,072	103,975	2,097	2.0%	100,781
						OPERATING EXPENSES					
46	5,241	5,043	(198)	-3.9%	4,652	Salaries & Wages	49,442	47,855	(1,587)	-3.3%	45,104
47	2,203	2,199	(4)	-0.2%	2,148	Employee Benefits	20,200	20,345	145	0.7%	20,372
48	844	701	(143)	-20.4%	966	Professional Fees	7,342	6,201	(1,141)	-18.4%	10,317
49	1,630	1,602	(28)	-1.7%	1,727	Supplies	14,686	14,947	261	1.7%	15,462
50	684	594	(90)	-15.2%	552	Purchased Services	5,263	5,391	128	2.4%	4,759
51	91	91	-	0.0%	89	Rentals & Leases	859	819	(40)	-4.9%	770
52	291	325	34	10.5%	305	Depreciation & Amortization	2,596	2,780	184	6.6%	2,472
53	368	309	(59)	-19.1%	267	Other Operating Expenses	3,170	2,781	(389)	-14.0%	3,067
54	11,352	10,864	(488)	-4.5%	10,706	**Total Operating Expenses**	103,558	101,119	(2,439)	-2.4%	102,323
55	(594)	(603)	9	-1.5%	(547)	**Operating Profit / Loss**	2,514	2,856	(342)	-12.0%	(1,542)
						NON-OPERATING REVENUES (EXPENSES)					
56	753	753	-	0.0%	753	District Tax Revenue	6,923	6,778	145	-2.1%	6,685
57	8	28	(20)	-71.4%	14	Investment Income	100	252	(152)	-60.3%	381
58	(121)	(165)	44	0.0%	(130)	Less: Interest Expense	(1,151)	(1,485)	334	-22.5%	(1,233)
59	640	616	24	3.9%	637	**Total Net Non-Operating**	5,872	5,545	327	5.9%	5,833
60	46	13	33	253.8%	90	**Income Profit (Loss)**	8,386	8,401	(15)	-0.2%	4,291
						Profitability Ratios:					
61	-5.5%	-5.9%			-5.4%	Operating Margin %	2.4%	2.7%			-1.5%
62	0.4%	0.1%			0.9%	Profit Margin %	7.9%	8.1%			4.3%
63	2,017	1,947	(70)	-3.6%	1,842	SWB / APD	2,018	1,928	(90)	-4.6%	1,860
64	85.6%	66.7%			63.5%	SWB / Total Operating Expenses	67.2%	67.4%			64.0%
65	3,077	2,921	(155)	-5.3%	2,900	Total Operating Expenses / APD	3,000	2,859	(142)	-5.0%	2,907
66	31,400	37,696	(6,296)	-16.7%	33,000	I/P Gross Charges	342,516	363,449	(20,933)	-5.8%	336,810
67	19,149	16,448	2,701	16.4%	20,177	O/P Gross Charges	172,931	159,719	13,212	8.3%	168,253
68	**50,549**	**54,144**	**(3,595)**	**-6.6%**	**53,177**	**Total Gross Charges**	**515,447**	**523,168**	**(7,721)**	**-1.5%**	**505,063**

						Payor Mix (IP and OP)					
69	39%	42%	-3%		39%	Medicare %	38%	42%	-4%		41%
70	15%	14%	1%		15%	Medi-Cal %	16%	14%	2%		14%
71	14%	15%	-1%		16%	Managed Care HMO / PPO %	16%	15%	0%		15%
72	12%	9%	3%		10%	Medicare HMO %	11%	9%	2%		10%
73	7%	5%	2%		6%	Medi-Cal HMO %	6%	5%	1%		6%
74	0%	0%	0%		0%	Commercial %	0%	0%	0%		0%
75	1%	2%	-1%		1%	Worker's Comp %	1%	2%	-1%		2%
76	4%	4%	0%		6%	Other Government %	4%	4%	0%		6%
77	9%	8%	1%		7%	Self Pay /Charity %	8%	8%	0%		6%
						STATISTICS					
78	495	507	(12)	-2.4%	474	Admissions	4,780	4,865	(85)	-1.7%	4,770
79	508	507	1	0.2%	471	Discharges	4,804	4,865	(61)	-1.3%	4,757
80	2,292	2,589	(297)	-11.5%	2,291	Patient Days	22,937	24,574	(1,637)	-6.7%	23,475
81	76.4	86.3	(9.9)	-11.5%	76.4	Average Daily Census (ADC)	84.0	90.0	(6.0)	-6.7%	85.7
82	4.51	5.11	0.59	11.6%	4.86	Average Length of Stay (LOS)	4.77	5.05	0.28	5.5%	4.93
83	30	30			30	Days in Month	273	273			274
84	818	728	90	12.3%	759	Adjusted Discharges (AD)	7,229	7,003	227	3.2%	7,133
85	3,690	3,719	(29)	-0.8%	3,692	Adjusted Patient Days (APD)	34,518	35,373	(856)	-2.4%	35,202
86	123	124	(1)	-0.8%	123	Adjusted ADC (AADC)	126	130	(3)	-2.4%	128
87	97	111	(14)	-12.6%	102	Inpatient Surgeries	843	973	(130)	-13.4%	938
88	113	117	(4)	-3.4%	102	Outpatient Surgeries	956	1,018	(62)	-6.1%	942
89	**210**	**228**	(18)	-7.9%	**204**	**Total Surgeries**	**1,799**	**1,991**	(192)	-9.6%	**1,880**
90	2,837	2,844	(7)	-0.2%	3,105	ED Outpatient Visits	29,875	29,740	135	0.5%	30,226
91	3,360	2,987	373	12.5%	2,987	Ancillary Outpatient Visits	28,223	26,672	1,551	5.8%	26,672
92	113	117	(4)	-3.4%	102	Outpatient Surgeries	956	1,018	(62)	-6.1%	942
93	**6,310**	**5,948**	362	6.1%	**6,194**	**Total Outpatient Visits**	**59,054**	**57,430**	1,624	2.8%	**57,840**
94	397	412	(15)	-3.6%	380	Emergency Room Admits	4,085	3,902	183	4.7%	3,917
95	14.0%	14.5%			12.2%	% of Total E/R Visits	13.7%	13.1%			13.0%
96	80.2%	81.3%			80.2%	% of Acute Admissions	85.5%	80.2%			82.1%
97	600	561	39	7.0%	560	Worked FTE	609	587	22	3.7%	560
98	700	643	57	8.9%	641	Paid FTE	693	668	25	3.8%	644
99	4.88	4.53	0.35	7.8%	4.55	Worked FTE / AADC	4.82	4.54	0.27	6.0%	4.38
100	5.69	5.19	0.50	9.7%	5.21	Paid FTE / AADC	5.48	5.18	0.30	5.8%	5.01
101	2,887	2,738	149	5.4%	2,729	Net Patient Revenue / APD	3,050	2,919	131	4.5%	2,840
102	13,700	14,560	(860)	-5.9%	14,404	I/P Charges / Patient Days	14,933	14,790	143	1.0%	14,348
103	3,035	2,765	269	9.7%	3,258	O/P Charges / Visit	2,928	2,781	147	5.3%	2,909
104	1,420	1,356	(64)	-4.7%	1,260	Salary Expense / APD	1,432	1,353	(80)	-5.9%	1,281

DOCTORS MEDICAL CENTER

Board Presentation

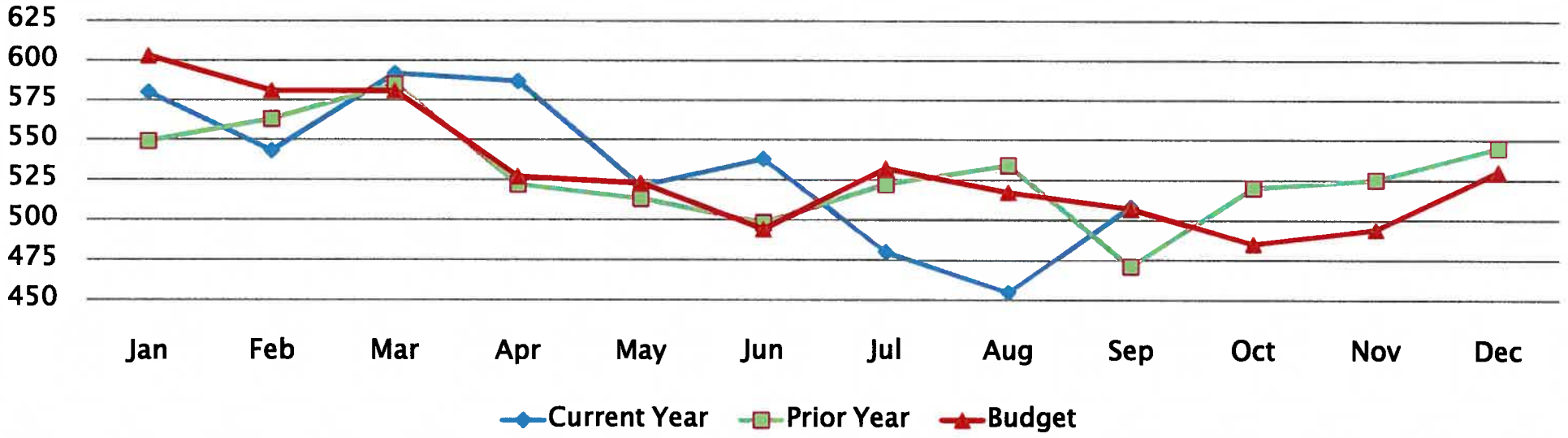
September 2009 Financial Report

October 28, 2009

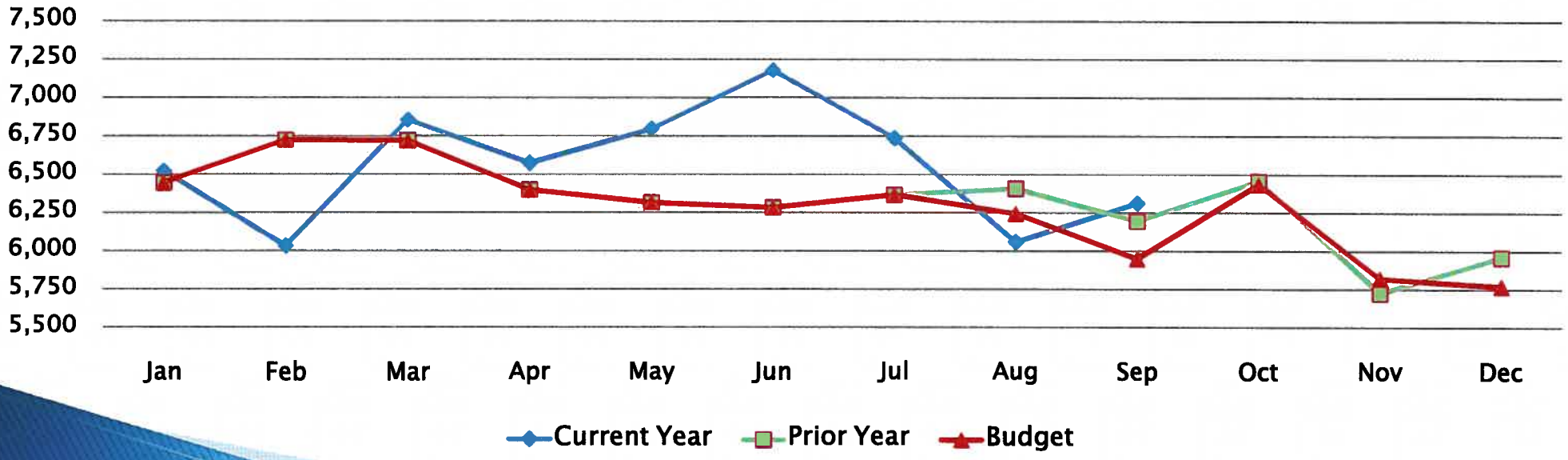
Patient Activity
For the Period Ending
September 30, 2009

Actual M.T.D.	Budget M.T.D.	Variance		Actual Y.T.D.	Budget Y.T.D.	Variance
508	507	1	**Inpatient Discharges**	4,804	4,865	(61)
6,310	5,948	362	**Outpatient Visits**	59,054	57,430	1,624

Inpatient Discharges



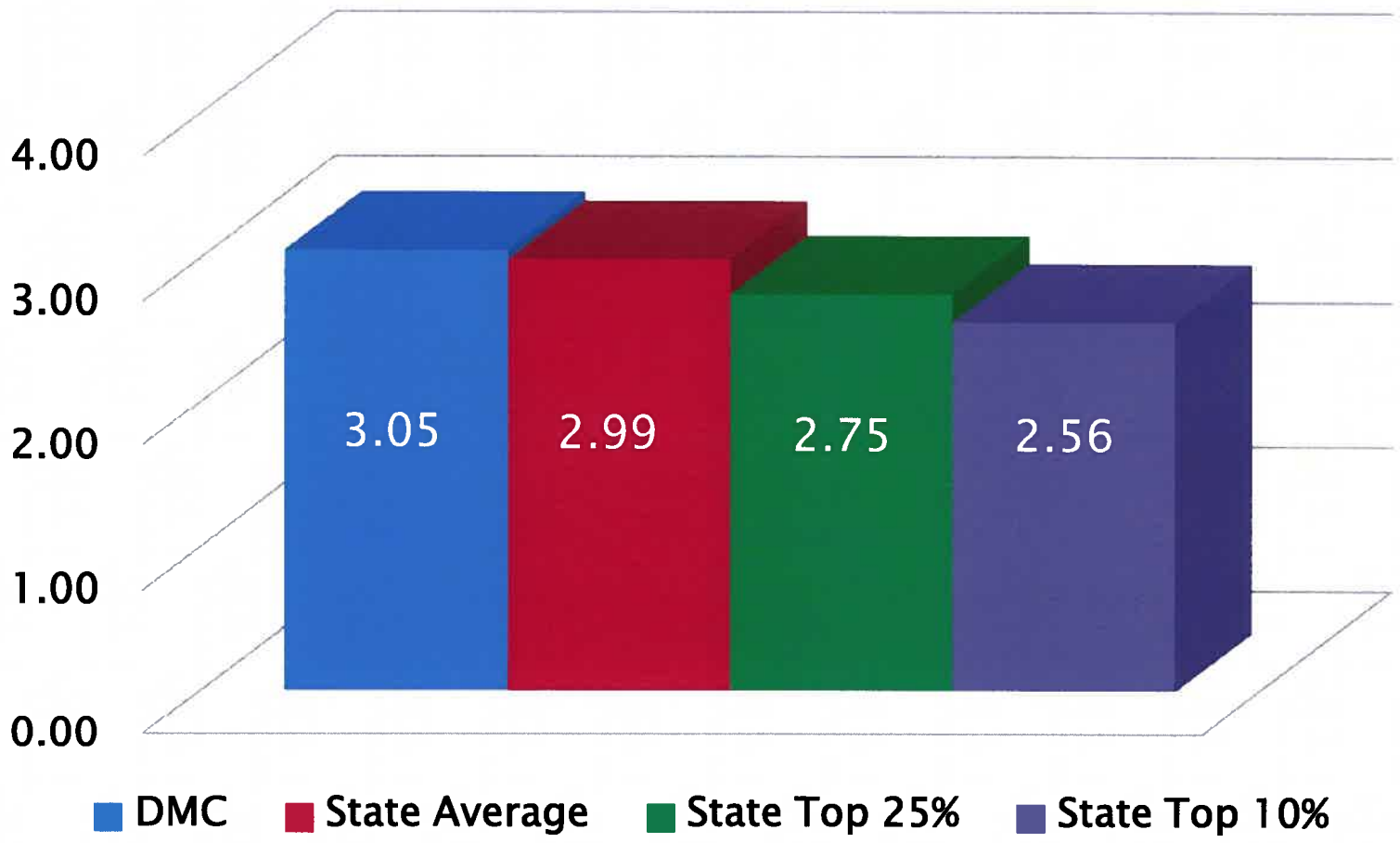
Out Patient Visits



Statement of Activity – Summary
For the Period Ending
September 30, 2009
(Thousands)

Actual M.T.D.	Budget M.T.D.	Variance		Actual Y.T.D.	Budget Y.T.D.	Variance
$10,758	$10,261	$497	**Net Operating Revenues**	$106,072	$103,975	$2,097
$11,352	$10,864	($488)	**Total Operating Expenses**	$103,558	$101,119	($2,439)
($594)	($603)	$9	**Income/(Loss) From Operations**	$2,514	$2,856	($342)
$640	$616	$24	**Income from Other Sources**	$5,872	$5,545	$327
$46	$13	$33	**Net Income/(Loss)**	$8,386	$8,401	($15)
0.4%	**0.1%**	**0.3%**	**Net Income Percentage**	**7.9%**	**8.1%**	**(0.2%)**
			California Benchmark Average	4.2%		
			Top 25%	10.5%		
			Top 10%	14.5%		

Length of Stay Comparison Adjusted For Case Mix Index



Cash Position
September 30, 2009
(Amounts in Thousands)

	September 30, 2009	December 31, 2008
Unrestricted Cash	$2,340	$7,218
Restricted Cash	$5,517	$8,566
Total Cash	$7,857	$15,784
Days Unrestricted Cash	6	18
Days Restricted	15	23
Total Days of Cash	21	41
California Benchmark Average	34	
Top 25%	82	
Top 10%	183	

Questions

Recommend approval of Outpatient Center Project to District Board

Tab 5

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY
AGENDA ITEM REQUEST / RECOMMENDATION
DOCUMENTATION FORM

TO: **DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY**

FROM: **David Ziolkowski, COO**

DATE: **October 28, 2009**

SUBJECT: **Lease Space at San Pablo Town Center**

REQUEST / RECOMMENDATION(S): Approve and authorize the Chief Operating Officer, or designee, to execute on behalf of DMC, to lease 11,500 sq. ft. of space to provide outpatient services at the San Pablo Towne Center.

FISCAL IMPACT: $26,000 monthly expense
The San Pablo Outpatient Center operations will be funded through the 2010 Operating budget. Sublease costs are accounted for the the Outpatient Center's business plan.

STRATEGIC IMPACT: DMC has been approached by a local primary care physician group (Alliance Medical Group, Inc) and a large local San Pablo employer to jointly provide outpatient and ambulatory care services in a new Outpatient Center proximate to DMC. Building an Outpatient Center will allow DMC to grow its outpatient business, alleviate parking and space constraints, and provide new services in a cost effective manner. The center will be co-located with Alliance Medical Group, Inc. to provide other urgent care, occupation health, and a full array of ancillary and diagnostic tests. The Outpatient Center will increase DMC's profitability an offer a great service to the community. The project will result in a positive contribution margin of $300,000 and pay for itself in just over two years.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: Management requests approval to sign a lease 11,500 sq. ft. from the Stanley Group at 100 San Pablo Town Center.
The key terms of the lease include:

Sq. Ft.	11,500
Term	5 years (3 renewable terms)
Price	$1.75 sq. ft. per month
Increase	2% per year
Common Costs	$0.50 year 1, $0.75 year 2-5
Start Date	July 1 2010

The lease has a term to allow JPA Management Authority to cancel the contract if tenant improvement costs exceed $1,500,000.

Presentation Attachments: Yes _X_ No ____

Requesting Signature: _____ Date: 10 / 28 / 09

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____
Vote of Board Members:

_____ Unanimous (Absent_____)
Ayes: _____ Noes: _____
Absent: _____ Abstain: _____

I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person: David Ziolkowski

Attested _____
Eric Zell, Management Authority Board Secretary

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

LEASE AGREEMENT

This Lease ("Lease") is dated for reference purposes only October 28, 2009 and is entered into by and between San Pablo Retail Partners, LLC as ("Landlord") and West Contra Costa Healthcare District as ("Tenant").

ARTICLE I
BASIC LEASE PROVISIONS

Each reference in this Lease to the "Basic Lease Provisions" shall mean and refer to the following terms, the application of which shall be governed by the provisions in the remaining Articles of this Lease:

1.	Address of Landlord:	c/o Russel W. Stanley San Pablo Retail Partners, LLC 18840 Saratoga Los Gatos Rd. Los Gatos, CA 95030
2.	Premises Address:	100A San Pablo Towne Center, San Pablo, CA 94806
3.	Address of Tenant:	100A San Pablo Towne Center, San Pablo, CA 94806
4.	Tenant's Trade Name; dba:	Doctors Medical Center
5.	Premises Square Footage:	Approximately 11,500 Square Feet
6.	Building Square Footage:	N/A
7.	Gross Floor Area of Project:	Approximately 92,711 Square Feet
8.	Tenant's Share (%)	6.19% CAM All, 12.26% CAM Building, 11.80% Tax & Assessments, 12.26% HVAC, 11.49% Insurance
9.	Anticipated Commencement Date:	July 1, 2010
10.	Lease Term:	Five (5) years, 3 renewable options
11.	Monthly Rental:	Nineteen thousand two hundred fifty Dollars and no Cents ($19,250.00), 2% annual increase
12.	Common Costs	Triple Net, negotiated at $0.50 per square foot year 1, $0.75 years 2-5
13.	Security Deposit:	Nineteen thousand two hundred fifty dollars and no cents ($19,250)
14.	Permitted Use:	Medical use only
15.	Broker(s):	Tenant: Security Pacific Real Estate Brokerage. Landlord: None
16.	Tenant's Architect:	BFHL
17.	Tenant's Liability Insurance:	Two Million Dollars ($2,000,000)
18.	Tenant's Right of Early Entry:	180 days
19.	Additional Insureds:	The Stanley Group, Inc., San Pablo Retail Partners, LLC
20.	Vehicle Parking Spaces:	Non-Exclusive Parking in the Parking Compound Area, not to exceed Tenant's Share of Total Parking at the Project.
21.	Tenant Improvement Allowance	None, negotiable over $1,500,000
22.	Termination Provision	Required tenant improvements in excess of $1,500,000 requires landlord to contribute amount above $1,500,000 for tenant improvements or allows tenant to terminate agreement before construction.

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY
AGENDA ITEM REQUEST / RECOMMENDATION
DOCUMENTATION FORM

TO: **DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY**

FROM: **David Ziolkowski, COO**

DATE: **October 28, 2009**

SUBJECT: **Sublease of San Pablo Towne Center –Alliance Medical Group.**

REQUEST / RECOMMENDATION(S): Approve and authorize the Chief Operating Officer, or designee, to execute on behalf of DMC, a sublease of 5,000 sq. ft. of medical space to Alliance Medical Group, Inc at San Pablo Towne Center.

FISCAL IMPACT: $10,000 monthly revenue
The San Pablo Outpatient Center operations will be funded through the 2010 Operating budget. Sublease costs are accounted for the the Outpatient Center's business plan.

STRATEGIC IMPACT: DMC has been approached by a local primary care physician group (Alliance Medical Group, Inc) and a large local San Pablo employer to jointly provide outpatient and ambulatory services in a new Outpatient Center proximate to DMC. Building an Outpatient Center will allow DMC to grow its outpatient business, alleviate parking and space constraints, and provide new services in a cost effective manner. The center will be co-located with Alliance Medical Group, Inc. to provide other priority care, occupation health, and a full array of ancillary and diagnostic tests. The Outpatient Center will increase DMC's profitability an offer a great service to the community. The project will result in a positive contribution margin of $300,000 and pay for itself in just over two years.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: Management requests approval to sign a sublease with Alliance Medical Group of 5,000 sq. ft. at 100 San Pablo Town Center

The key terms of the Letter of Intent include:

Sq. Ft.	5,000
Term	5 years (3 renewable terms)
Price	$1.75 sq. ft. per month
Increase	2% per year
Common costs	Triple Net $0.25 yr1, $0.40 yrs 2-5
Start Date	July 1, 2010

Presentation Attachments: Yes X No ____

Requesting Signature: _____ Date: 10 / 28 / 09

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____
Vote of Board Members:

_____ Unanimous (Absent_____)
Ayes: _____ Noes: _____
Absent: _____ Abstain: _____

I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person: David Ziolkowski

Attested _____
Eric Zell, Management Authority Board Secretary

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

SUBLEASE AGREEMENT

This Lease ("Lease") is dated for reference purposes only October 28, 2009 and is entered into by and between West Contra Costa Healthcare District as ("Sublessor") and Alliance Medical Group as ("Sublessee").

ARTICLE I
BASIC LEASE PROVISIONS

Each reference in this Lease to the "Basic Lease Provisions" shall mean and refer to the following terms, the application of which shall be governed by the provisions in the remaining Articles of this Lease:

1.	Address of Sublessor:	West Contra Costa Healthcare District 2000 Vale Road San Pablo, CA 94806
2.	Premises Address:	100A San Pablo Towne Center, San Pablo, CA 94806
3.	Address of Sublessee:	100A San Pablo Towne Center, San Pablo, CA 94806
4.	Premises Square Footage:	Approximately 5,000 Square Feet
5.	Building Square Footage:	N/A
6.	Gross Floor Area of Project:	Approximately 92,711 Square Feet
7.	Sublessee's Share (%)	6.19% CAM All, 12.26% CAM Building, 11.80% Tax & Assessments, 12.26% HVAC, 11.49% Insurance
8.	Anticipated Commencement Date:	July 1, 2010
9.	Lease Term:	Five (5) years, 3 renewable options
10.	Monthly Rental:	Ten Thousand Dollar and no cents ($10,000), 2% annual increase
11.	Common Costs	Triple Net, negotiated at $0.25 per square foot year 1, $0.40 years 2-5
12.	Security Deposit:	Eight Thousand Seven Hundred Fifty Dollars and no cents ($8,750)
13.	Permitted Use:	Medical use only
14.	Broker(s):	Tenant: None Landlord: None
15.	Sublessor's Architect:	BFHL
16.	Subleseer's Liability Insurance:	Two Million Dollars ($2,000,000)
17.	Sublessee's Right of Early Entry:	180 days
18.	Vehicle Parking Spaces:	Non-Exclusive Parking in the Parking Compound Area, not to exceed Tenant's Share of Total Parking at the Project.

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY
AGENDA ITEM REQUEST / RECOMMENDATION
DOCUMENTATION FORM

TO: **DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY**

FROM: **David Ziolkowski, COO**

DATE: **October 28, 2009**

SUBJECT: **Tenant Improvements for San Pablo Outpatient Center**

REQUEST / RECOMMENDATION(S): Approve and authorize the Chief Operating Officer, or designee, to execute on behalf of DMC, a public "hard bid" process to cost and build tenant improvements for the San Pablo Outpatient Center.

FISCAL IMPACT: $1,500,000
This will be funded through the 2009/2010 Capital budget.

STRATEGIC IMPACT: DMC has been approached by a local primary care physician group (Alliance Medical Group, Inc) and a large local San Pablo employer to jointly provide outpatient and ambulatory care services in a new Outpatient Center proximate to DMC. Building an Outpatient Center will allow DMC to grow its outpatient business, alleviate parking and space constraints, and provide new services in a cost effective manner. The center will be co-located with Alliance Medical Group, Inc. to provide other priority care, occupation health, and a full array of ancillary and diagnostic tests. The Outpatient Center will increase DMC's profitability an offer a great service to the community. The project will result in a positive contribution margin of $300,000 and pay for itself in just over two years.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: Cost estimates for the San Pablo Outpatient Center have ranged from under $1,000,000 to $1,600,000. Variability in the number exists due to a lack of design documents and construction documents. With those documents completed, a strong open "hard bid" and value engineering process will allow DMC to finalize costs and dirve costs savings through the project. In conjunction with the building owner, we have concluded we can build out the tenant improvement for an amount less than $1,500,000.

Negotiated in the San Pablo Towne Center lease, Doctors Medical Center has the authority to cancel our lease if tenant improvements exceed $1,500,000.

Presentation Attachments: Yes _X_ No ____

Requesting Signature: _____ Date: 10 / 28 / 09

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____
Vote of Board Members:

_____ Unanimous (Absent_____)
Ayes: _____ Noes: _____
Absent: _____ Abstain: _____

I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person: David Ziolkowski

Attested _____
Eric Zell, Management Authority Board Secretary

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY
AGENDA ITEM REQUEST / RECOMMENDATION
DOCUMENTATION FORM

TO: **DOCTORS MEDICAL CENTER MANAGEMENT AUTHORITY**

FROM: **David Ziolkowski, COO**

DATE: **October 28, 2009**

SUBJECT: **Construction Documents and Equipment Costs for San Pablo Outpatient Center**

REQUEST / RECOMMENDATION(S): Approve and authorize the Chief Operating Officer, or designee, to execute on behalf of DMC, a contract to finalize the construction documents and purchase of equipment at the San Pablo Outpatient Center.

FISCAL IMPACT: $796,442
This will be funded through the 2009/2010 Capital budget. The majority of the equipment will be leased and is factored into the Outpatient Center business plan.

STRATEGIC IMPACT: DMC has been approached by a local primary care physician group (Alliance Medical Group, Inc) and a large local San Pablo employer to jointly provide outpatient and uambulatory care services in a new Outpatient Center proximate to DMC. Building an Outpatient Center will allow DMC to grow its outpatient business, alleviate parking and space constraints, and provide new services in a cost effective manner. The center will be co-located with Alliance Medical Group, Inc. to provide other priority care, occupation health, and a full array of ancillary and diagnostic tests. The Outpatient Center will increase DMC's profitability an offer a great service to the community. The project will result in a positive contribution margin of $300,000 and pay for itself in just over two years.

REQUEST / RECOMMENDATION REASON, BACKGROUND AND JUSTIFICATION: Included in the scope of approval are the construction documents, design documents, bid and construction management required for the Outpatient Center, as well as all the furniture, equipments, and fictures required to run the Ouptatient Center.

Presentation Attachments: Yes -X- No ____

Requesting Signature: _____ Date: 10 / 28 / 09

SIGNATURE(S):

Action of Board on ___ / ___ / ___ Approved as Recommended _____ Other _____
Vote of Board Members:

_____ Unanimous (Absent_____)
Ayes: _____ Noes: _____
Absent: _____ Abstain: _____

I HEREBY CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF AN ACTION TAKEN AND ENTERED ON THE MINUTES OF THE BOARD ON THE DATE SHOWN.

Contact Person: David Ziolkowski

Attested _____
Eric Zell, Management Authority Board Secretary

Cc:
Accounts Payable
Contractor
CFO/Controller
Requestor

DOCTORS MEDICAL CENTER

DMC Outpatient Center

Doctors Medical Center Management Authority, JPA Board

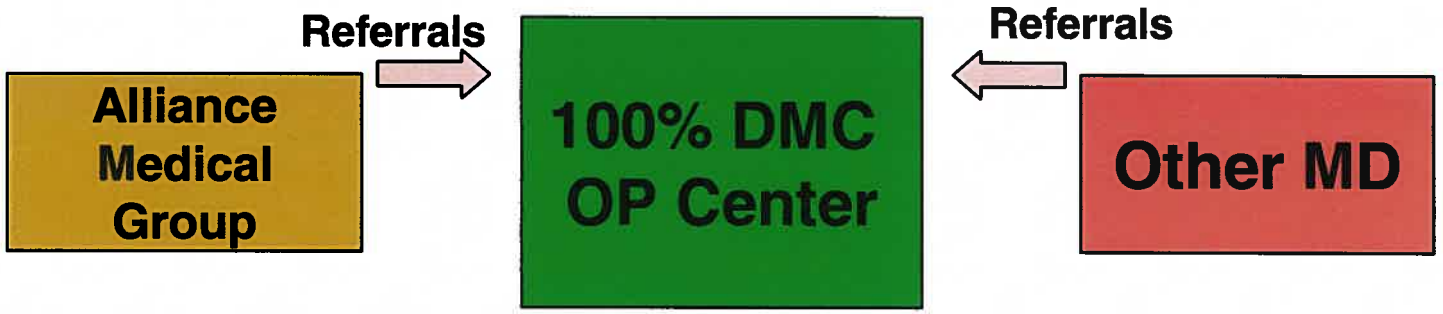
October 28, 2009

Rationale

- Respond to growing community need for outpatient and convenient medical services
- Improve DMC community visibility
- Decompress hospital congestion with facilities and parking
- Strategically work with largest primary care physician group
- Improve DMC profitability through outpatient business growth

Delivery Model

San Pablo Towne Center OP Center



- Simplest Implementation
- No New Entity, Same Organizations
- Same Contracts & Billing Procedures
- Positive DMC Margin

- Primary Care Physician Alignment
- Union Growth
- 100% DMC Capitalized
- Shared Space

Proposed Services
(7:00 am – 7:00 pm / Sat)

Doctors Medical Center	ALLIANCE MEDICAL GROUP	SHARED
Lab Draw Station	Primary care physician offices	Check-in
X-Ray	MD/PA Staffed	Registration
Physical Therapy	Priority Care Availability	Waiting Area
Cardiac Rehab	MD/PA Staffed Occupational Medical Services	Data Interface for Single point of Entry and Results Reporting
Occupational Therapy	Specialist Office	
Echocardiography		
EKG		
Pre-Op Testing		
Wellness Services		


A
B
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4
5
SUPPORT
MULTIPURPOSE
STORAGE
O
NURSE
BAY 1
BAY 2
BAY 3
BAY 4
HYDRO
CARDIO
PT
WORK
SUPPORT
BAY 5
BAY 6
HAND
KITCHEN
O
T
STAFF LOUNGE
EKG
U/S
E
E
E
E
STORAGE
O
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TECH
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LAB
TREATMENT
RECEPTION
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WAITING
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Department Legend
Affinity
DMC
Shared

Equipment & Other Costs

Department		Amount
Admitting	Total Expenses	$1,142.06
Cardiac Rehab	Total Expenses	$22,044.49
Information Systems	Total Expenses	$92,890.59
Laboratory	Total Expenses	$9,786.46
Furniture, Fixtures, Interior	Total Expenses	$53,550.00
Occupational/Physical Therapy	Total Expenses	27,587.86
Radiology	Total Expenses	$353,173.75
Telecom	Total Expenses	$16,103.31
Planning, Design Docs, and Bid Mgmt.	Total Expenses	$229,950.00
GRAND TOTAL EXPENSES:		**$796,442.06**

Financials

	Year 1	Year 2	Year 3	Year 4	Year 5
INCREMENTAL OPERATIONS					
Revenue					
Net Patient Revenue	$1,224,650	$1,404,698	$1,597,769	$1,804,694	$2,026,353
Operating Expenses					
Total Operating Expenses	1,213,182	1,331,962	1,352,150	1,424,420	1,426,282
OP Center Revenue over Expenses	$ 11,468	$ 72,736	$ 245,619	$ 380,274	$ 600,071
Pull Through Revenue	295,100	309,855	325,348	341,615	358,696
Total Improved Margin	$ 306,568	$ 382,591	$ 570,967	$ 721,889	$ 958,767

INCREMENTAL OPERATIONS					
Intitial Investment	($1,500,000)				
Cash Flow	$606,568	$682,591	$870,967	$1,021,889	$1,258,767
Payback	$ (893,432)	$ (210,841)	$ 660,126	$ 1,682,015	$ 2,940,782

~2.25 Years

**** Initial investment includes only cost of tenant improvements as equipment will be leased***

Recommendations

- Approve signing 5-year lease with Landlord based on signed LOI
  - Cost $26,000 monthly / $312,000 annual
- Approve signing 5-year sublease with Alliance Medical Group based on terms of LOI
  - Income $10,000 monthly / $120,000 annual
- Approve tenant improvement budget of $1,500,000
- Approve equipment budget & contracts to develop construction/design documents & manage “hard bid” process of $796,442

Project Financial Risks

- 5-year net lease commitment with cost of $16,000 monthly / $192,000 annually
- Tenant improvements of $1,500,000

Approval of Resolution: Maintain current wage for non-represented employees

Tab 6

RESOLUTION NO. 2009 - 04

A RESOLUTION OF DOCTORS MEDICAL CENTER
MANAGEMENT AUTHORITY, JPA BOARD
RELATING TO EMPLOYER-EMPLOYEE RELATIONS

WHEREAS, Section 3500 of the Government Code of the State of California states that one of its purposes is to promote the improvement of employer-employee relations between public employers and their employees by establishing uniform and orderly methods of communication between employees and the public; and

AND WHEREAS, the Doctors Medical Center Management Authority, JPA Board has determined that the interests of the Medical Center are best served by declining to increase salaries, wages and all forms of compensation ("wage freeze") for those Medical Center employees not represented by a labor organization,

NOW THEREFORE, Management Authority, JPA Board resolves as follows:

1.1 The Medical Center will maintain the wage freeze, as described above, until June 30, 2010, but will continuously review its economic status and market conditions.

1.2 The wage freeze will apply to:

1.2.1 All employees not represented by labor organizations;

1.2.2 All current salaries, wages, differentials and other forms of compensation, in whatever form.

SECTION 2: EFFECTIVE DATE

This resolution shall be effective _____, 2009.

PASSED AND ADOPTED THIS _____ day of _____, 2009 by the following vote:

AYES:

NOES:

ABSENT

John Gioia, Chair
Doctors Medical Center Management
Authority, JPA Board

ATTEST:

Eric Zell, Secretary
Doctors Medical Center Management
Authority, JPA Board

Joint Commission Report

Tab 7

The Joint Commission

Doctors Medical Center San Pablo
2000 Vale Road
San Pablo, CA 94806

Organization Identification Number: 10111

Program(s)
Hospital Accreditation

Surveyor(s) and Survey Date(s)
Byron K.Kitagawa - (09/30 - 09/30/2009)
Susan M.Oemichen, MS, RN - (09/30 - 10/02/2009)
Alan M.Rapaport, MBA, MD - (09/30 - 10/02/2009)
Conrad Salinas, MD - (10/01 - 10/01/2009)

Executive Summary

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Findings

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day this report is posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.04.03	EP2
	IC.02.02.01	EP2
	MM.05.01.09	EP1
	NPSG.02.02.01	EP3
	NPSG.03.04.01	EP2,EP3,EP5
	PC.01.02.07	EP3
	PC.03.01.07	EP2

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day this report is posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	LD.04.01.05	EP4
	MM.03.01.01	EP3
	MS.06.01.03	EP6
	MS.06.01.05	EP3,EP8
	MS.08.01.03	EP1
	NPSG.02.03.01	EP5,EP6
	PC.01.03.01	EP23
	PI.01.01.01	EP11
	PI.02.01.01	EP6
	RC.01.01.01	EP19
	RC.02.01.07	EP1
	RI.01.03.01	EP6

*** OCO - Observed Corrected Onsite.**

CoP: §482.11 **Tag:** A-0020 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.11 Condition of Participation: Compliance with Federal, State and Local Laws

CoP Standard	Tag	Corresponds to	Deficiency
§482.11(c)	A-0023	HAP - MS.06.01.03/EP6	Standard

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(a)(1)	A-0340	HAP - MS.06.01.05/EP3	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(b)(4)	A-0396	HAP - PC.01.03.01/EP23	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(1)(i)	A-0454	HAP - RC.01.01.01/EP19	Standard

CoP: §482.25 **Tag:** A-0490 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(2)(i)	A-0502	HAP - MM.03.01.01/EP3	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(c)(2)	A-0724	HAP - EC.02.04.03/EP2	Standard

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.04.03 ESC 45 days

Standard Text: The hospital inspects, tests, and maintains medical equipment.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

2. The hospital inspects, tests, and maintains all life-support equipment. These activities are documented. (See also EC.02.04.01, EPs 3 and 4; PC.02.01.11, EP 2) 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:
Observed in 4th Floor at Doctors Medical Center- San Pablo Campus site.
During tracer activity the logs of the daily defibrillator checks that were required by hospital policy were reviewed. On the 4th floor there were two defibrillators. The defibrillator log labeled 2077 did not have documentation of daily checks on 9/8, 9/3, 8/24, 8/25, 8/7, 6/8, 6/12, 6/15-16, 7/14, 7/27, and 5/8-12. The defibrillator log labeled 2070, that was located on the other side the same unit, did not have documentation of daily checks on 9/8, 9/3, 6/10 and 6/18.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01 ESC 45 days

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Primary Priority Focus Area: Infection Control

Element(s) of Performance:

2. The hospital implements infection prevention and control activities when doing the following: Sterilizing medical equipment, devices, and supplies. (See also EC.02.04.03, EP 4) 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in Decontamination at Doctors Medical Center- San Pablo Campus site.
A Condition of Participation does not apply to this observation.
During tracer activity the log of biological tests and controls was reviewed for the Steris machines. Control samples were run with once with each lot. This resulted in a control sample being run once every 10 to 20 days. The manufacturer's recommendation stated, "biological controls should be performed, preferably every day a microbiological test is performed." Additionally, the log did not indicate the lot number of the respective tests and controls to confirm that controls were run for each lot tested.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.01.05 ESC 60 days

Standard Text: The hospital effectively manages its programs, services, sites, or departments.

Primary Priority Focus Area: Communication

Element(s) of Performance:

4. Staff are held accountable for their responsibilities. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4
Observed in ICU at Doctors Medical Center- San Pablo Campus site.
A Condition of Participation does not apply to this observation.
During a patient tracer it was identified that a physician had signed a consent for a procedure when the hospital was unable to contact the family. A follow up review of the documentation identified that a second physician had signed the consent following the initial review of the chart. This entry was not dated or timed. The second physician performed this procedure two days earlier.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.06.01.03 ESC 60 days

Standard Text: The hospital collects information regarding each practitioner's current license status, training, experience, competence, and ability to perform the requested privilege.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

6. The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information: 
- The applicant's current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration
- The applicant's relevant training
- The applicant's current competence
(See also PC.03.01.01, EP 1)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
§482.11(c) - (A-0023) - (c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.
This Standard is NOT MET as evidenced by:
Observed in Medical Staff Credentialing at Doctors Medical Center- San Pablo Campus site.
During review of credential files, the file of a licensed independent practitioner whose license expired May 31, 2008 did not have verification of renewal of licensure until June 27, 2008.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.06.01.05

ESC 60 days

Standard Text: The decision to grant or deny a privilege(s), and/or to renew an existing privilege (s), is an objective, evidenced-based process.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

3. All of the criteria used are consistently evaluated for all practitioners holding that privilege. 

Scoring Category : A
Score : Insufficient Compliance

8. Peer recommendation includes written information regarding the practitioner's current: 

- Medical/clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal skills
- Communication skills
- Professionalism

Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.22(a)(1) - (A-0340) - (1) The medical staff must periodically conduct appraisals of its members.
This Standard is NOT MET as evidenced by:
Observed in Medical Staff Credentialing at Doctors Medical Center- San Pablo Campus site.
Review of physician Credentials files revealed that privileges were granted for a procedure which the physician has not done for more than five years.

EP 8
Observed in document review at Doctors Medical Center- San Pablo Campus site.
A Condition of Participation does not apply to this observation.
Review of new physician Credential files reveals that requests for letter of recommendations do not address all of the required core competencies: specifically, the requests for letter of recommendation do not ask about clinical knowledge or communication skills.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.08.01.03 ESC 60 days

Standard Text: Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

Primary Priority Focus Area: Credentialed Practitioners

Element(s) of Performance:

1. The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice. 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in document review at Doctors Medical Center- San Pablo Campus site.
A Condition of Participation does not apply to this observation.
In review of physician Credentials files, a well-defined process for ongoing professional practice evaluation was initiated only two months ago.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.03.01.01 ESC 60 days

Standard Text: The hospital safely stores medications.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

3. The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation. 4 OCO
Note: Scheduled medications include those listed in Schedules II–V of the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.25(b)(2)(i) - (A-0502) - (2)(i) All drugs and biologicals must be kept in a secure area, and locked when appropriate.
This Standard is NOT MET as evidenced by:
Observed in 7th Floor at Doctors Medical Center- San Pablo Campus site.
CORRECTED ON SITE. The medication cabinets in the medication room on a closed patient care unit were unlocked. The medication room was secured with a keypad lock, however the medications were accessible to facility staff during the Life Safety tour. The Life Safety Specialist was able to hold a vial of Propofol. He stated there were many other medications in the cabinet. Other unauthorized individuals could potentially have had access to these medications. The pharmacy removed the medications from this vacated area during the survey.

Chapter: Medication Management
Program: Hospital Accreditation
Standard: MM.05.01.09 ESC 45 days
Standard Text: Medications are labeled.
Primary Priority Focus Area: Medication Management
Element(s) of Performance:

1. Medication containers are labeled whenever medications are prepared but not immediately administered. 3
Note: An immediately administered medication is one that is prepared or obtained, taken directly to a patient, and administered to that patient by an authorized staff member, without any break in the process.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in 5th Floor at Doctors Medical Center- San Pablo Campus site.
During tracer activity the nurse was directly observed drawing insulin into a syringe in the medication room for administration. The nurse did not label the syringe with the contents of the syringe. The nurse then left the medication room and took the medication into the patient's room. During discussions with the clinical pharmacist it was confirmed that the organizational expectation was that the medication would be labeled in the medication room prior to transport to and administration in a patient room

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Chapter: National Patient Safety Goals
Program: Hospital Accreditation
Standard: NPSG.02.02.01 ESC 45 days
Standard Text: There is a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the hospital.
Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

3. The hospital implements the 'do not use' list of abbreviations, acronyms, symbols, and dose designations and applies it to all orders and all medication-related documentation that is handwritten or entered as free text into a computer.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 3
Observed in ICU at Doctors Medical Center- San Pablo Campus site.
During a patient tracer the dangerous abbreviation "u" was found hand written by a nurse on the heparin flow sheet.

Observed in ICU at Doctors Medical Center- San Pablo Campus site.
During a patient tracer the dangerous abbreviation "u" was found hand written by a physician in an order for heparin.

Observed in 5th Medical at Doctors Medical Center- San Pablo Campus site.
During a patient tracer it was noted that the dangerous abbreviation "u" was hand written in an order for RBC's.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.02.03.01

ESC 60 days

Standard Text: The hospital measures, assesses, and, if needed, takes action to improve the timeliness of reporting and the timeliness of receipt of critical tests and critical results and values by the responsible licensed caregiver.

Primary Priority Focus Area: Patient Safety

Element(s) of Performance:

5. The hospital collects data on the timeliness of reporting critical test results and critical results and values from routine tests.

Scoring Category : A
Score : Insufficient Compliance

6. The hospital assesses the data on the timeliness of reporting critical test results and critical results and values from routine tests and determines whether a need for improvement exists.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
Observed in ICU at Doctors Medical Center- San Pablo Campus site.
During a patient tracer it was noted that a critical lab result was called to the nurse on September 20 at 2200. This critical result was documented on the appropriate sticker and placed on the physician order sheet. The physician signed this sticker at 0740 on September 21. There was no documentation of physician notification prior to his signature. Discussion with nursing and quality department leadership indicated that data was not being collected on the timeframes from when a nurse was notified of a critical result by lab to the time the physician was notified .

Observed in Data System tracer at Doctors Medical Center- San Pablo Campus site.
Discussions with quality leadership indicated that the hospital was not collecting data on the timeliness of reporting critical results from the radiology department or for critical ABG results from respiratory therapy.

EP 6
Observed in ICU at Doctors Medical Center- San Pablo Campus site.
During follow up on an identified critical lab result and discussions with lab supervisors and quality leadership, it was noted that the lab collected a large amount of data on critical results, however this data was not aggregated or analyzed by the hospital.

Chapter: National Patient Safety Goals

Program: Hospital Accreditation

Standard: NPSG.03.04.01 ESC 45 days

Standard Text: Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

Primary Priority Focus Area: Medication Management

Element(s) of Performance:

2. Labeling occurs when any medication or solution is transferred from the original packaging to another container. 

Scoring Category : A
Score : Insufficient Compliance

3. Medication or solution labels include the medication name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours. 

Scoring Category : A
Score : Insufficient Compliance

5. No more than one medication or solution is labeled at one time. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in operating room at Doctors Medical Center- San Pablo Campus site.
Observation in the Operating Room revealed that anesthetic medications were drawn into pre-labeled syringes.

EP 3
Observed in Cath Lab at Doctors Medical Center- San Pablo Campus site.
During tracer activity the nurse was directly observed to label two syringes with preprinted labels. The labels were printed with the name of the medications but the strength of the medication was not on the label and the nurse did not update the labels to reflect the drug strength.

EP 5
Observed in Cath Lab at Doctors Medical Center- San Pablo Campus site.
During tracer activity the nurse was directly observed to remove two syringes to be used for medications for conscious sedation. The nurse placed a label on each syringe and then after both syringes were labeled, the syringes were filled with medications.

Chapter: Performance Improvement
Program: Hospital Accreditation
Standard: PI.01.01.01 ESC 60 days
Standard Text: The hospital collects data to monitor its performance.
Primary Priority Focus Area: Quality Improvement Expertise/Activities
Element(s) of Performance:

11. The hospital collects data on the following: The results of resuscitation. (See also LD.04.04.01, EP 2) 

Scoring Category : A
Score : Partial Compliance

Observation(s):

EP 11
Observed in Data System Tracer at Doctors Medical Center- San Pablo Campus site.
A Condition of Participation does not apply to this observation.
The hospital has been collecting data on the results of resuscitation since February 2009. This is a track record issue.
Current data collection on the results of resuscitation is complete.

Chapter: Performance Improvement
Program: Hospital Accreditation
Standard: PI.02.01.01 ESC 60 days
Standard Text: The hospital compiles and analyzes data.
Primary Priority Focus Area: Quality Improvement Expertise/Activities
Element(s) of Performance:

6. The hospital analyzes data from ORYX core measures that, over three or more consecutive quarters for the same measure, identify the hospital as a negative outlier. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
Observed in Data System Tracer at Doctors Medical Center- San Pablo Campus site.
The hospital did not analyze data from the Surgery ORYX core measures that, over the last six consecutive quarters, had statistically significant performance issues.

Observed in Data System tracer at Doctors Medical Center- San Pablo Campus site.
The hospital did not analyze data from the Pneumonia ORYX core measures that, over the last six consecutive quarters, had statistically significant performance issues.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.01.02.07 ESC 45 days
Standard Text: The hospital assesses and manages the patient's pain.
Primary Priority Focus Area: Assessment and Care/Services
Element(s) of Performance:

3. The hospital reassesses and responds to the patient's pain, based on its reassessment criteria. 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 3
Observed in 5th Medical at Doctors Medical Center- San Pablo Campus site.
During a patient tracer it was noted that the patient had received medication for pain at 2130 on September 27. There was no documentation of the patient's pain level prior to the administration of the medication and there was no reassessment of the patient's pain 30 to 60 minutes after the administration of the pain medication as required by hospital policy.

Observed in 5th Medical at Doctors Medical Center- San Pablo Campus site.
During a patient tracer it was noted that the patient had received medication for pain at 1230 on September 29 from a second nurse. There was no documentation of the patient's pain level prior to the administration of the medication and there was no reassessment of the patient's pain 30 to 60 minutes after the administration of the pain medication as required by hospital policy.

Chapter: Provision of Care, Treatment, and Services
Program: Hospital Accreditation
Standard: PC.01.03.01 ESC 60 days
Standard Text: The hospital plans the patient's care.
Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

23. The hospital revises plans and goals for care, treatment, and services based on the patient's needs. (See also RC.02.01.01, EP 2) 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 23
§482.23(b)(4) - (A-0396) - (4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.
This Standard is NOT MET as evidenced by:
Observed in ICU at Doctors Medical Center- San Pablo Campus site.
During a patient tracer it was noted that the patient was assessed as high risk for falls. The care plan was not updated to include interventions specific to this fall risk as required by hospital policy.

Observed in Closed Chart Review at Doctors Medical Center- San Pablo Campus site.
The patient was placed in restraints "to protect the patient" for five days. There was no documentation of any goals, interventions, or updates to the care plan during these five days to address the patient's unique needs while restrained.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.01.07 ESC 45 days

Standard Text: The hospital provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.

Primary Priority Focus Area: Assessment and Care/Services

Element(s) of Performance:

2. The hospital monitors the patient's physiological status, mental status, and pain level at a frequency and intensity consistent with the potential effect of the operative or other high risk procedure and/or the sedation or anesthesia administered. 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 2
Observed in ICU at Doctors Medical Center- San Pablo Campus site.
A Condition of Participation does not apply to this observation.
During a patient tracer it was identified that the patient had received moderate sedation for a bronchoscopy performed in the ICU. The vital signs were documented every hour during the procedure and following the procedure. Hospital policy required that vital signs are monitored and documented "not less than every 15 minutes during the procedure" and "every 15 minutes times 4" following the procedure.

Observed in closed chart review at Doctors Medical Center- San Pablo Campus site.
A Condition of Participation does not apply to this observation.
During a closed chart review for a patient that had received moderate sedation for a bronchoscopy, it was identified that the vital signs were documented every hour during the procedure and following the procedure. Hospital policy required that vital signs are monitored and documented "not less than every 15 minutes during the procedure" and "every 15 minutes times 4" following the procedure.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01 ESC 60 days

Standard Text: The hospital maintains complete and accurate medical records.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

19.
For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed. 4

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 19
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:
Observed in Closed Record Review at Doctors Medical Center- San Pablo Campus site.
The time out documentation form was completed and dated, however the entries on this form were not timed.

§482.24(c)(1)(i) - (A-0454) - (i) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section.
This Standard is NOT MET as evidenced by:
Observed in 4th Floor at Doctors Medical Center- San Pablo Campus site.
During tracer activity the record was reviewed and orders written on 9/27, 9/28 and 9/29 were identified where the time the order was written was not documented with the order.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.02.01.07 ESC 60 days

Standard Text: The medical record contains a summary list for each patient who receives continuing ambulatory care services.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

1. A summary list is initiated for the patient by his or her third visit. 4

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in 7th Floor at Doctors Medical Center- San Pablo Campus site.
During tracer activity the file for a patient seen at the CDCR clinic who had been seen at least three times was reviewed and a summary list had not been initiated.

Observed in 7th Floor at Doctors Medical Center- San Pablo Campus site.
During tracer activity the file for a second patient seen at the CDCR clinic who had been seen at least three times was reviewed and a summary list had not been initiated.

Observed in 7th Floor at Doctors Medical Center- San Pablo Campus site.
During tracer activity the file for a third patient seen at the CDCR clinic who had been seen at least three times was reviewed and a summary list had not been initiated. The organization did not have a process to initiate a summary list in the CDCR clinic after three visits.

Chapter: Rights and Responsibilities of the Individual

Program: Hospital Accreditation

Standard: RI.01.03.01

ESC 60 days

Standard Text: The hospital honors the patient's right to give or withhold informed consent.

Primary Priority Focus Area: Rights & Ethics

Element(s) of Performance:

6. The hospital's written policy describes when a surrogate decision-maker may give informed consent. (See also RI.01.02.01, EP 6)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 6
Observed in ICU at Doctors Medical Center- San Pablo Campus site.
A Condition of Participation does not apply to this observation.
During a patient tracer it was identified that the primary physician had signed the consent form for the bronchoscopy when the family was not available to consent. California laws require a signatures by two physicians.

The Joint Commission

Doctors Medical Center San Pablo
2000 Vale Road
San Pablo, CA 94806

Organization Identification Number: 10111

Program(s)
Laboratory Accreditation

Surveyor(s) and Survey Date(s)
Frederick Olivier, MT - (09/16 - 09/18/2009)

Executive Summary

As a result of the survey conducted on the above date(s), the following survey findings have been identified. Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.

If you have any questions, please do not hesitate to contact your Account Representative.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

The Joint Commission
Summary of Findings

DIRECT Impact Standards:

Program:	Laboratory Accreditation Program	
Standards:	QC.1.20	EP7,EP8

INDIRECT Impact Standards:

Program:	Laboratory Accreditation Program	
Standards:	EC.6.20	EP8,EP14
	EC.8.10	EP19
	QC.1.150	EP1
	QC.2.30	EP1
	WT.1.40	EP5

Chapter: Management of Environment of Care

Program: Laboratory Accreditation

Standard: EC.6.20

Standard Text: Laboratory equipment is maintained, tested, and inspected.

Primary Priority Focus Area: Equipment Use

Element(s) of Performance:

8. The laboratory documents and retains, for at least two years, any daily, weekly, monthly, quarterly, or semi-annual performance testing and function checks.* * See the 'Quality Control' chapter for details of CLIA'88 requirements for calibration and calibration verification. 

Scoring Category : C
Score : Partial Compliance

14. The laboratory documents monitoring of temperature-controlled spaces and equipment.**For blood warmers and blood bank storage alarms, the activation temperature is recorded and remedial action is taken when the results are outside the acceptable range. 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 8
Observed in the blood bank department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. For the two year period reviewed, there was no daily documentation that the gel centrifuge timer began at 10 minutes an timed down to 0.0 minutes as recommended by manufacturer.

Observed in the blood bank department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. For the two year period reviewed, there was no daily documentation of the gel centrifuge RPM readings as recommende by manufacturer.

EP 14
Observed in the biomedical department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. For blood warmer maintenance, the temperature verification was not documented for the first six months of 2009. The blood warmer temperature was 41°C (+- 1°). The actual temperature of the verifying thermometer was not documented

Observed in the biomedical department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. In 2008, for the initial blood warmer maintenance, the temperature verification was not documented. The blood warmer temperature was 41°C (+- 1°). The actual temperature of the verifying thermometer was not documented.

Chapter: Management of Environment of Care

Program: Laboratory Accreditation

Standard: EC.8.10

Standard Text: The laboratory establishes and maintains an appropriate environment.

Primary Priority Focus Area: Physical Environment

Element(s) of Performance:

19. Sufficient workspace exists and is configured to efficiently handle and house equipment and reagents so as not to adversely affect test outcomes or compromise staff safety. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 19
Observed in the microbiology department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834 There was insufficient functional space in the microbiology department. Equipment took up most of the bench working space. There was no space for storage of supplies needed for daily operations. Also, there was no space to perform dail clerical work.

Chapter: Quality Control

Program: Laboratory Accreditation

Standard: QC.1.150

Standard Text: The laboratory retains quality control records as required by law or regulation.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

1. The laboratory retains all quality control records for at least two years including test system performance specifications that the laboratory establishes and verifies, and quality system assessments. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in the serology department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. For serum HCG testing, the internal quality controls were documented as "internal controls acceptable". Both positive an negative internal quality control must be documented.

Chapter: Quality Control

Program: Laboratory Accreditation

Standard: QC.1.20

Standard Text: Proficiency testing services used for specialty and subspecialty* equal or exceed applicable laws and regulations with respect to variety and frequency of testing and satisfactory performance criteria.
*This includes the specialty of Microbiology, sub-specialties of Bacteriology, Mycobacteriology, Mycology, Parasitology, and Virology; specialty of Immunology, sub-specialties of Syphilis Serology and general Immunology; Specialty of Chemistry, sub-specialties of routine Chemistry, Endocrinology, and Toxicology; Specialty of Hematology; Specialty of Pathology, sub-specialty of Cytology (limited to gynecologic examinations); and specialty of Immunohematology (ABO group and D (Rho) typing, unexpected antibody detection, compatibility testing, and antibody identification).

Primary Priority Focus Area: Analytic Procedures

Element(s) of Performance:

7. For each specialty, subspecialty, analyte, or test, the laboratory's proficiency test performance is satisfactory.Note 1: The laboratory's proficiency test performance is satisfactory according to the following: • Attaining a score of at least 80% for all specialties, subspecialties, or tests, except ABO group and D (RHo) typing and compatibility testing• Attaining a score of at least 100% for ABO group and D (RHo) typing or compatibility testing• Returning proficiency testing results to the proficiency testing provider within the timeframe specified by that provider (Note: Failure to return proficiency testing results to the proficiency testing provider within the timeframe specified by that provider results in a score of 0 for the testing event)• No omission of results on the proficiency testing form (Note: Omission of results could lead to a failure of attaining the score necessary for satisfactory performance (see bullets 1 and 2))• Participating in a proficiency testing event* (Note: Failure to participate in a proficiency testing event which results in a score of 0 for the testing event) Note 2: Most proficiency testing events with less than 10 participants automatically result in a score of 100% for the event. These challenges are not sufficient for demonstrating the laboratory has met satisfactory performance criteria. If this occurs, laboratories must supplement with either interlaboratory comparisons as specified under QC.1.60 or non -CMS approved proficiency testing provided by the instrument manufacturer*Consideration may be given to those laboratories failing to participate in a testing event only if the following occurs:-Patient testing was suspended during the time frame allotted for testing and reporting proficiency testing results-The laboratory notified the inspecting agency and the proficiency testing program within the time frame for submitting proficiency testing results of the suspension of patient testing and the circumstances associated with failure to perform tests on proficiency testing samples-The laboratory participated in the previous two proficiency testing events

Scoring Category : C
Score : Insufficient Compliance

8. For each specialty, sub-specialty, analyte, or test, the laboratory's proficiency test performance is successful as required by law and regulation.Note: Unsuccessful performance is defined as a failure to achieve satisfactory performance for two consecutive or two out of three consecutive testing events.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 7
Observed in the chemistry department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. An unsatisfactory proficiency test result (60%) was obtained for pCO2 in the first event of 2008. Adequate remedial actio had been documented and subsequent events were successful.

Observed in the chemistry department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. An unsatisfactory proficiency test result (40%) was obtained for total CK in the third event of 2007. Adequate remedial action had been documented and subsequent events were successful.

Observed in the chemistry department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. An unsatisfactory proficiency test result (60%) was obtained for alcohol in the first event of 2008. Adequate remedial action had been documented and subsequent events were successful.

EP 8
Observed in the blood bank department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. Proficiency testing failure had occurred for compatibility testing in the third proficiency testing event of 2007 and the second event of 2008. A successful action plan had been submitted and accepted by TJC.

Observed in the parasitology department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. Proficiency testing failure had occurred for parasitology identification in the first and third proficiency testing event of 2008. A successful action plan had been submitted and accepted by TJC.

Chapter: Quality Control

Program: Laboratory Accreditation

Standard: QC.2.30

Standard Text: Surgical specimens are accompanied by pertinent clinical information and preoperative and postoperative diagnoses to the degree known.

Primary Priority Focus Area: Communication

Element(s) of Performance:

1. Requests for examining surgical specimens are accompanied by a preoperative and postoperative diagnoses to the degree known. 

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
Observed in the pathology department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. For 2008, requests for histopathology examination often did not include clinical information necessary for expedient accurate diagnosis. Significant history was absent on 40% of the requisitions requiring pertinent history for tissue processing. Pertinent clinical information is required with the requisition and tissue specimen for all histopathology examinations. Absence of required relevant medical history can delay tissue processing and affect accurate diagnosis.

Observed in the pathology department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. For 2009, requests for histopathology examination often did not include clinical information necessary for expedient accurate diagnosis. Significant history was absent on 40% of the requisitions requiring pertinent history for tissue processing. Pertinent clinical information is required with the requisition and tissue specimen for all histopathology examinations. Absence of required relevant medical history can delay tissue processing and affect accurate diagnosis.

Chapter: Waived Testing

Program: Laboratory Accreditation

Standard: WT.1.40

Standard Text: Policies and procedures governing specific testing-related processes are current, approved, and readily available.

Primary Priority Focus Area: Information Management

Element(s) of Performance:

5. Written policies, procedures, and manufacturer's instructions are followed. 

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
Observed in the emergency department at Doctors Medical Center- San Pablo Campus site for CLIA #(s) 05D0603834. For urine dipstick testing performed in the emergency department, insert sheets with expected ranges were not retained for the two year period required. In addition the quality control lot numbers on the log sheets did not match the insert sheet retained.

CEO and Quality Report

Tab 8

Quality & Safety

Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care

UCSF Center for California Health Workforce Studies

February 2009

In 2004, California began requiring that acute-care hospitals maintain certain minimum ratios between nurses and patients, making it the first state in the nation to do so. However, little is known about what effects the staffing ratios have had, either on the hospitals themselves or the quality of care they provide.

This issue brief examines how California's nurse staffing regulations affected different types of hospitals in order to probe what strategies were used to meet the ratio requirements; whether the ratios influenced hospitals' financial performance; and what effect they had on improving patient care. The research combined quantitative and qualitative analysis, including interviews with executives and other management staff at 12 acute-care hospitals.

The results show that while the legislation has increased the use of registered nurses, the ratios have had no clear impact on the quality measures that are associated with nursing care. The study also found no relationship between the staffing regulations and the overall decline in hospital operating margins that occurred after the law went into effect.

The full issue brief is available under Document Downloads below.

Document Downloads

PDF Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care (269K)

Help with Document Downloads and Media Players

California HealthCare Foundation
1438 Webster Street Suite 400, Oakland, CA 94612
Tel: 510.238.1040 Fax: 510.238.1388

Assessing the Impact of California's Nurse Staffing Ratios on Hospitals and Patient Care

CALIFORNIA HEALTHCARE FOUNDATION

ISSUE BRIEF

FEBRUARY 2009

Introduction

In 2004, California became the first state to establish minimum nurse-to-patient staffing requirements in acute-care hospitals. Little is known about how these regulations affected California's hospitals, the market for nursing labor, or the quality of hospital care. While research and news reports do indicate that hospital staffing of licensed nurses increased between 2002 and 2004 and employment of unlicensed nursing assistants dropped,[1-3] some hospitals did not meet the ratios in the first year of their implementation[4-6] and no significant impact on the quality of patient care has been measured.[7-9]

Prior studies have focused on average changes in staffing and patient outcomes across all California hospitals. This study, in contrast, examines how the minimum staffing regulations affected different types of hospitals, categorizing them according to ownership, financial position before the ratios were enacted, and mix of patients. The research then probes three issues:

- What strategies did hospitals use to meet the staffing requirements?
- Are the ratios associated with changes in hospital financial status?
- Did the ratios improve the quality of hospital care?

The results show that the nurse staffing legislation resulted in higher use of registered nurses in most California hospitals. Implementation of the staffing regulations could not be tied to changes in hospital finances; rather, changes in Medicare and Medi-Cal payment rates and demands to address seismic building requirements had far greater effects on finances. Hospital administrators found that it was challenge to meet the staffing requirements, particularly in ensuring that staff were available at all times, including during breaks and meals. Finally, many of the health care leaders interviewed for the study expressed an expectation that the minimum staffing ratios would increase the quality of care due to increased interaction with patients; however, there was no evident change in patient length of stay or adverse patient safety events. None of these findings were affected by hospital ownership, financial position, or patient mix.

Background

In 1999, the California State Assembly passed AB 394, mandating that the state establish minimum nurse-to-patient staffing in acute-care hospitals. Between 1999 and 2002, the California Department of Health Services developed registered and licensed vocational nurse-to-patient ratios.[10,11] The law went into effect in January 2004 with specific ratios for different types of hospital units; for example, the minimum ratio in medical-surgical units was one nurse per six patients. The ratios were to be adjusted in January 2005 to require fewer patients per nurse in selected units; for example, the ratio in medical-surgical units would have dropped to one to five. This change was suspended in November 2004 by the Schwarzenegger administration, but the suspension was invalidated by the Sacramento County Superior Court in March 2005. Court challenges by the California Hospital Association proved unsuccessful, and the additional ratio regulations went into full effect on April 7, 2005.[12]

Licensed vocational nurses (LVNs) may make up half of the licensed nurses in this ratio, but whether they can be employed to this extent in practice depends on the needs of patients in the hospital. The legal scope of practice for LVNs, who must work under the direction of physicians or registered nurses (RNs), does not include administration of intravenous medications or the assessment of patients; thus, in most hospitals LVNs can have full responsibility for only a small share of patients. In addition, hospitals have tended to underuse LVNs by limiting their role to an even greater degree than the legal scope of practice requires.[13]

Little is known about how the minimum staffing regulations affected hospitals, nursing labor markets, or the quality of hospital care in California. In fact few studies had been conducted from which the state could develop the ratio requirements. A literature review conducted for the California Department of Health Services noted that only a handful of recent studies and reviews had demonstrated consistent relationships between staffing levels for licensed nurses and the quality of patient care, and none identified an ideal staffing ratio for hospitals.[14,15] The few publications that examined the effect of California's ratios reported that many hospitals did not appear to be meeting the standard in 2004—the first year of the regulation.[16–18] Recent research also found that licensed nursing staff increased notably between 2002 and 2004, while employment of unlicensed nursing assistants dropped; however, no significant improvement in the quality of patient care could be detected.[19–21]

Because the papers published to date have focused on average changes in staffing, patient outcomes, and hospital finances across all California hospitals, they may not capture the full impact of the ratios, since minimum staffing regulations may have had different effects on different types of hospitals. Previous studies have found that some hospitals—such as those with a high share of publicly insured patients—are more likely to report a shortage of nurses; these hospitals may have found it particularly difficult to recruit and retain nurses to meet the staffing regulations. Hospitals that were in weak financial positions prior to the enactment of the ratio legislation may not have had the financial resources to pay for more nurses. Differences in hospitals' ability to respond to the regulations may in turn result in variation in the benefit to patients.

For the research reported in this issue brief, the methods used by hospitals to meet the staffing requirements were explored: Did permanent employment increase? Did hiring and retention change? Were more temporary agency nurses used? Changes in hospital financial positions were also examined. Finally, patient safety measures were compared to learn whether the implementation of the staffing regulations was associated with improvements in patient safety. For each of these three topics, hospitals were categorized by their ownership, financial position before the ratios were enacted, and mix of patients to learn whether the impact of minimum staffing ratios varied across hospitals.

Methodology

This study combined quantitative analysis of several data sets with qualitative analysis of interviews conducted at 12 hospitals. Quantitative analysis of the impact of the regulations on staffing, fiscal, and health care outcomes was conducted for 410 general acute-care hospitals from 1999 through 2007. The main sources of data were three datasets collected by the California Office of Statewide Health Planning (OSHPD). With these data, changes in the hours worked by registered nurses, licensed vocational nurses, aides and orderlies, and agency-employed nurses were examined using the annual hospital disclosure reports. The fiscal health of each hospital was determined by comparing operating margins before and after ratios, using the quarterly hospital financial data. A set of nursing-sensitive metrics devised by the Agency for Healthcare Research and Quality (AHRQ) was calculated for hospitals reporting thirty or more patients at risk for

an incident during one time period, using the patient discharge data.

Changes in employment also were studied using the base wage file of the California Employment Development Department (EDD) from 1998 through 2007. These data compile wage and employment information that are primarily collected for unemployment insurance and disability insurance programs. The base wage file does not include occupation data, so it was not possible to identify registered nurses. Thus, all analyses of turnover were conducted for all hospital employees. Since RNs account for about one-third of hospital employees, it is expected that hospital-wide turnover rates will reflect proportional changes in nurse staffing. The final database included 244 employers. Due to the confidentiality of wage and employer information, all analyses of these data were performed by the EDD.

All quantitative data were first analyzed for all hospitals combined. The analyses were then repeated for three categorizations of hospitals: profit status (public, for-profit, and nonprofit), fiscal strength (fiscally strongest, fiscally weakest, and average fiscal position), and patient demographics (i.e., those serving higher-income populations with few recent immigrants; those whose patient mix includes a disproportionate share of lower-income, non-resident, or homeless patients; and average patient mix). Table 1 presents the number of each category of hospital included in this study.

Table 1: Number of Hospitals in the Study, by Type

Nonprofit	223
For-profit	125
District	41
Public	30
Fiscally Strong (average operating margin: 10.9 percent)	42
Fiscally Weak (average operating margin: −15.8 percent)	31
Lower-income Patients (average share of patients in public programs: 64.7 percent)	71
Higher-income Patients (average share of patients in public programs: 51.7 percent)	39
TOTAL	**410**

Interviews were conducted with 23 chief nursing officers, chief nurse executives, vice presidents of nursing, chief executive officers, emergency department directors, and other managers and directors. Hospitals selected for the case studies were chosen to represent a range of financial and recruiting positions from good to weak. Twenty hospitals were contacted for the study, with 12 agreeing to participate. Seven of the 12 hospitals are nonprofits, four are public hospitals, and one is for-profit. The researchers also interviewed several people currently or recently employed in the insurance industry to learn how the ratio regulations were addressed in contract negotiations between hospitals and payers.

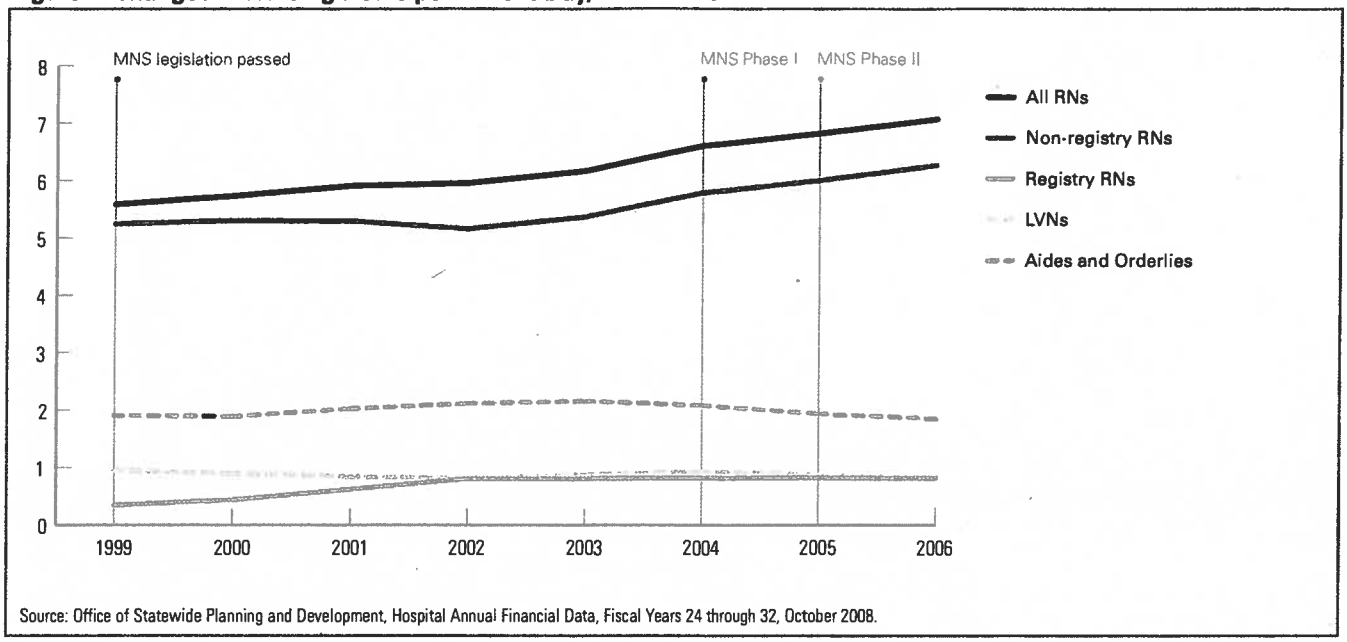
Findings

Staffing Changes and Challenges

The nurse staffing legislation resulted in higher employment of licensed nurses in most California hospitals. Figure 1 presents changes in hours worked by RNs, LVNs, and aides/orderlies between 1999 and 2006. The hours worked by regular RN employees and agency RNs also are indicated. RN hours per patient day increased throughout this period, with more rapid growth after 2002. Agency RN hours rose notably between 2000 and 2002. After 2002, RN hours per patient day for non-agency RNs increased. The levels of LVN and aide hours were fairly stable throughout the entire period.

Figure 2 compares RN hours per patient day before and after 2004, for all hospitals and by type of hospital. Prior to the enactment of the ratios, nonprofit hospitals had the highest number of RN hours per patient day, while district, for-profit, and fiscally weak hospitals had fewer RN hours per patient day. After the ratios were implemented, average RN hours per patient day increased for hospitals overall, as well as for each type of hospital. This growth varied by type of hospital. One might expect that staffing would have increased more among hospitals that had lower initial staffing; however, this is not the case for the groups presented in Figure 2. Less growth in RN

Figure 1: Changes in Nursing Hours per Patient Day, 1999–2006

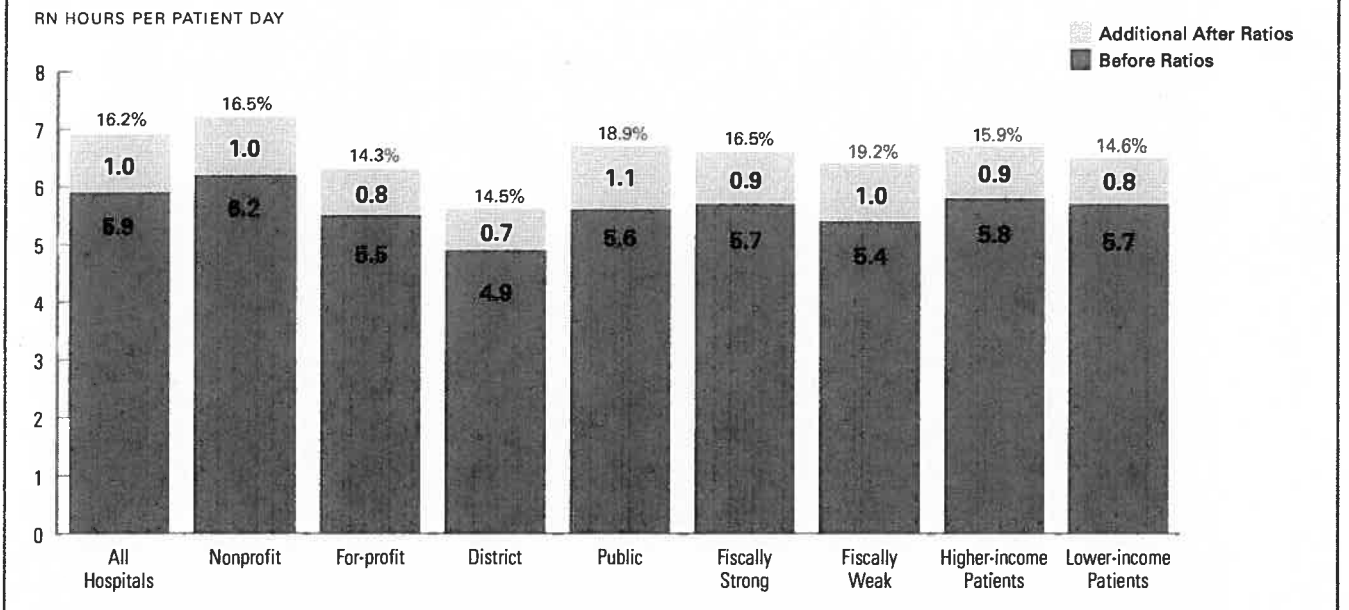


Source: Office of Statewide Planning and Development, Hospital Annual Financial Data, Fiscal Years 24 through 32, October 2008.

hours per patient day was observed for district hospitals, for-profit hospitals, and hospitals with lower-income patients—all of which had initial staffing below the statewide average.

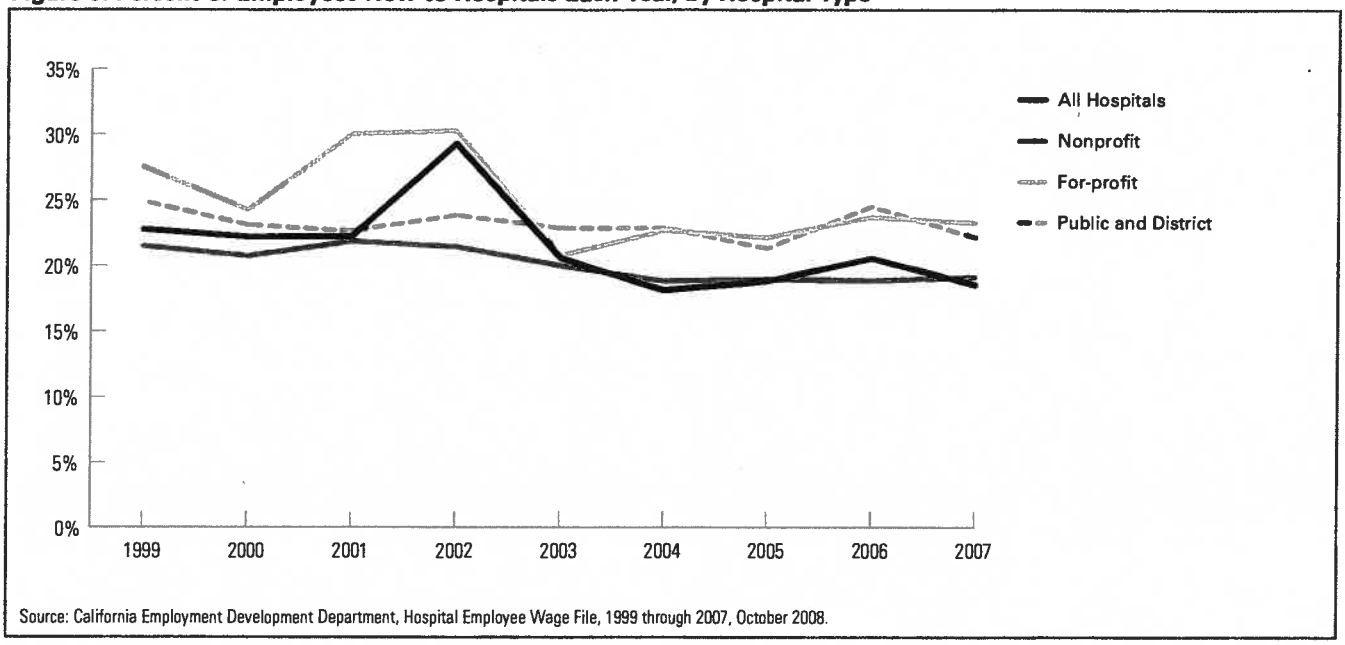
Figure 3 examines hospital hiring of new employees from 1999 through 2007, as calculated from the EDD's base wage file. Hiring peaked in 2002 for all hospitals, with an average of 29 percent of employees being new to their

Figure 2: Changes in Average Nursing Hours per Patient Day, by Hospital Type, Before and After 2004



Source: Office of Statewide Planning and Development, Hospital Annual Financial Data, Fiscal Years 24 through 32, October 2008.

Figure 3: Percent of Employees New to Hospitals Each Year, by Hospital Type



Source: California Employment Development Department, Hospital Employee Wage File, 1999 through 2007, October 2008.

hospitals that year. For-profit hospitals increased their hiring earlier, in 2001. This is not surprising because staffing levels at for-profit hospitals were below the statewide average before the ratios were implemented, which meant they had a greater need to hire to meet the regulations. Hiring by nonprofit hospitals was comparatively stable over time, though it decreased somewhat after 2001. Hiring by public hospitals, which in Figure 3 includes district hospitals, also was fairly stable between 1999 and 2007. Hospitals that served a greater proportion of higher-income patients engaged in more hiring throughout this time period, with hiring rising notably in 2003, dropping in 2004, and then rising again through 2007. Hospitals that served more lower-income/ non-resident patients increased hiring somewhat in 2001 and 2002, but decreased hiring after 2004. Fiscally strong hospitals did more hiring than fiscally weak hospitals, but the difference was not large. (In the interest of clarity, the data tracking patient demographics and financial strength were not included in Figure 3.)

The hospital leaders interviewed for this study reported that they faced many challenges as the staffing regulations were put in place. Prior to the implementation of the ratios in 2004, most hospitals had completed financial and staffing assessments. A few interviewees reported that staffing ratios at their hospitals or units were already at or above the mandated levels, but most reported that they needed to hire more RNs to meet the requirements, particularly to cover meals and breaks. California's labor code regulates how many meal breaks employees must receive based upon shift length, and the interaction of this regulation with the minimum staffing requirement posed a particular challenge.

The majority of the individuals interviewed for this study, both at high-performing and under-performing hospitals, discussed the problems associated with meeting the "at all times" requirement of the ratios law in conjunction with meal breaks for staff. This challenge was addressed with a wide variety of solutions. Many created "float pools" to have a supply of staff to cover meal breaks. Charge nurses and nurses from registries are also used to cover meal breaks. One hospital created a position whereby a nurse works a truncated shift for the sole purpose of providing meal breaks. Several interviewees noted that the need to cross-train staff increased, particularly in specialty areas, in order to increase float coverage. Some interviewees

thought the implementation of the ratios increased tension between management and staff, and associated this with rules regarding meal breaks. The combination of meal break and staffing regulations was perceived as reducing the ability of staff nurses to use their professional judgment in determining the best time to take a break, and interviewees believed that nurses found this loss of autonomy frustrating.

Nine of the 12 hospitals that participated in the interviews reported that 90 percent or more of their nursing staff were RNs, and six hospitals said they employ traveling or agency nurses to meet staffing requirements. Many hospital leaders reported difficulty finding specialty nurses or experienced nurses holding bachelor's or master's degrees, noting that new graduates are not appropriate for some positions. Interviewees also noted that they could not readily use LVNs to meet the staffing regulations due to their limited scope of practice. Because only RNs can assess patients and administer intravenous medications those few hospitals that used LVNs had to partner them with RNs; some of the nursing managers reported that their RN staff thought this arrangement increased their workload, since they had to provide care to both their own and the LVN's patients while supervising the LVN. A reduction of ancillary staff support was reported at several of the hospitals. These reductions resulted in additional primary care duties for the RNs, such as giving baths to patients. Managers reported hearing from their RN staff that they were unhappy with these additional job tasks and the shift in their role in patient care. These issues were of equal importance among both high-performing and under-performing hospitals.

Overwhelmingly, interviewees said they want some flexibility in applying the ratios. particularly the removal of the "at all times" language. The lack of flexibility was singled out as the reason hospitals have trouble remaining in compliance, since it is expensive and challenging to maintain the mandated ratios at all times and in all contingencies, such as days when too many nurses call in sick. Another recommendation focused on using acuity-based ratios, so as to avoid situations where the minimum staffing regulations dictate a lower ratio than was generally thought of as necessary, or vice versa. The night shift and patients waiting to be discharged were both cited as examples of situations requiring fewer nurses than the ratios prescribe. On the other hand, caring for patients with complex conditions, such as multiple and chronic illnesses, was cited as an example of an area where the staffing ratios fell short of meeting the patient's needs.

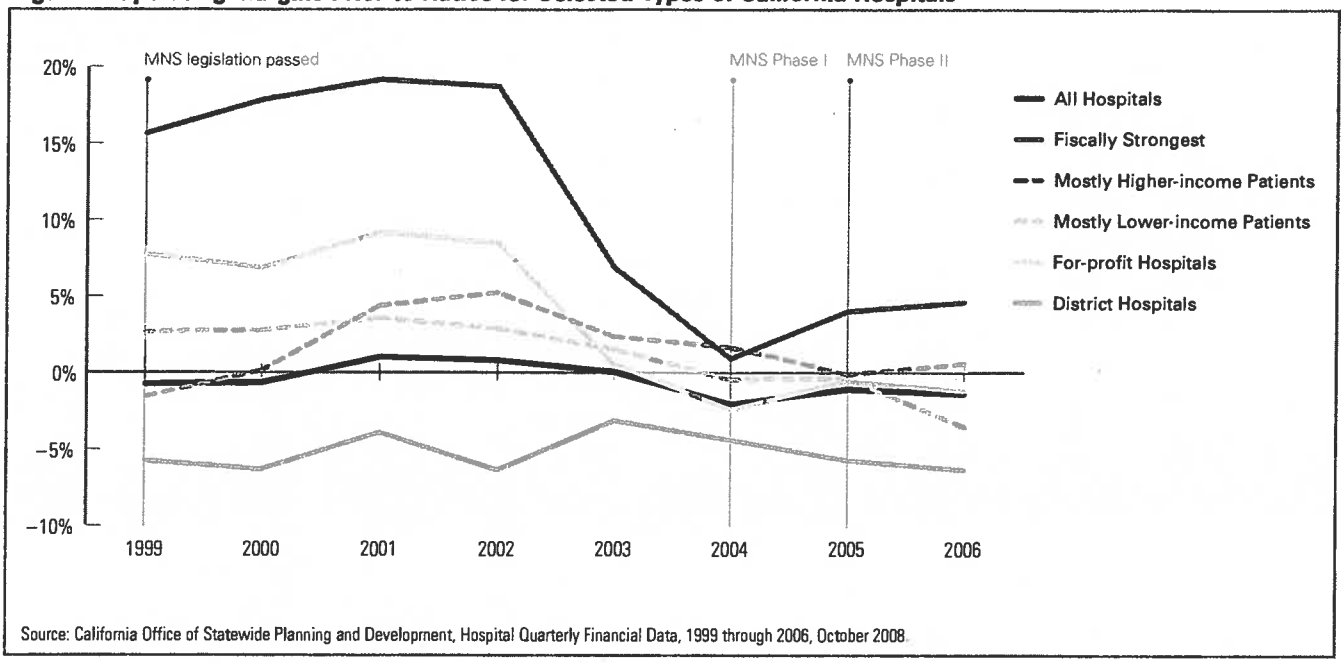
Fiscal Stability and Change

Over the eight years examined in this study, California's hospitals experienced decreasing operating margins; however, these changes could not be tied directly to the nurse staffing legislation. A variety of financial policies had a substantial effect on hospitals from 1999 to 2007.

Medicare margins severely declined as the Balanced Budget Act of 1997 constricted government payment rates and Medicare significantly changed its billing procedures and payment streams.[22,23] After a series of emergency state funding bills, California had fewer hospitals reporting operating deficits in 2005 than in 1999. However, in late 2005, the state began enacting a series of changes in Medicaid funding that, along with new changes in Medicare funding, sought to decrease government transfers to safety-net hospitals.

As a result of these policies and trends, by 1999, the first year examined in this study, California hospitals had experienced significant declines in operating margins. Hospitals started to recover from these fiscal woes in 2001, but by 2004 margins had declined again. These declines occurred primarily in district hospitals, for-profit hospitals, hospitals serving higher-income or lower-income patients, and hospitals that prior to 2002 were fiscally strongest (Figure 4). Public, nonprofit, and the fiscally weakest hospitals experienced increases in operating margins over the same period, while public hospital margins declined after 2004. Due to

Figure 4: Operating Margins Prior to Ratios for Selected Types of California Hospitals



Source: California Office of Statewide Planning and Development, Hospital Quarterly Financial Data, 1999 through 2006, October 2008.

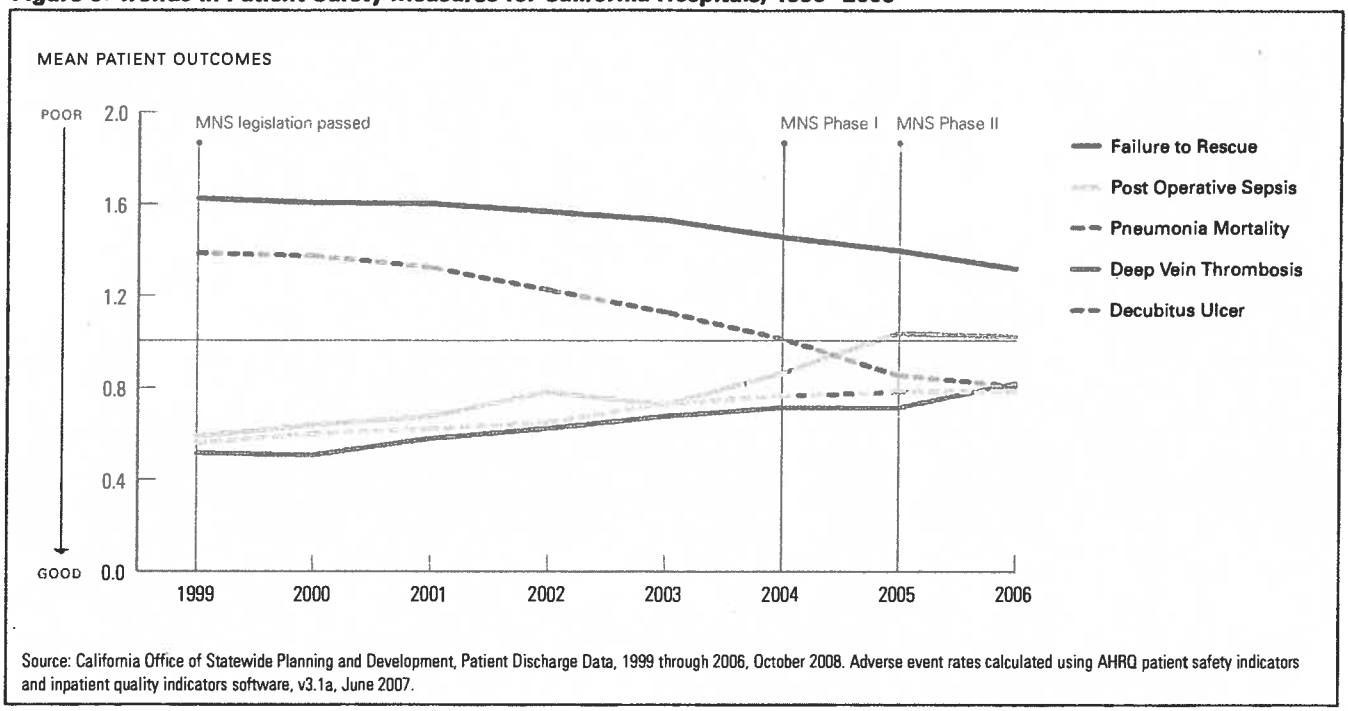
these pre-ratio trends, most hospital types experienced statistically significant variation in operating margin after ratios. (The two exceptions were district hospitals and those serving mostly higher-income patients.) While the ratio regulations may have influenced the amount of change experienced by each hospital type, this analysis cannot isolate any such effect. In fact, it is likely that the staffing requirements had at most a marginal impact on hospital financial stability.

Several of the nursing executives and managers reported that the staffing legislation made it easier to secure additional funding or avoid budget cuts within their own hospitals, particularly for hiring nursing staff. However, CEOs at both high- and under-performing hospitals said that it was difficult to absorb costs related to the ratios. They noted that they needed to find funds from other budget areas, which in some cases involved the reduction of some services. A small number reported that their hospitals successfully obtained higher insurance reimbursement rates from insurers to defray some of the increased costs. The insurers interviewed for this study indicated that hospitals have cited the minimum ratios as one reason for rising costs, and that these costs are likely passed on to the consumer.

Quality of Care

The desired outcome of minimum nurse staffing legislation was the improvement of patient outcomes; however, most of the quality measures analyzed for this study do not appear to have been directly affected by the increase in RN staffing. For example, one of the metrics sensitive to nursing care, average length of patient stay, showed very low rates of change during the study period. Average length of stay did not change for nonprofit hospitals, increased significantly in public hospitals, and decreased significantly among for-profit hospitals. As a result, the overall level of average length of stay in California has stayed the same since the ratios were imposed. Other nursing-sensitive measures such as decubitus (pressure) ulcers, failure to rescue after a post-surgical complication, deep vein thrombosis/ pulmonary embolism (DVT), pneumonia mortality, and postoperative sepsis show similar results. Figure 5 shows the average ratio of observed patient incidents over expected patient incidents for all California hospitals.

Figure 5: Trends in Patient Safety Measures for California Hospitals, 1998–2006



Source: California Office of Statewide Planning and Development, Patient Discharge Data, 1999 through 2006, October 2008. Adverse event rates calculated using AHRQ patient safety indicators and inpatient quality indicators software, v3.1a, June 2007.

Ratios greater than one indicate poorer quality, whereas rates less than one indicate better quality. California performed better than expected through the entire period for rates of DVT and decubitus ulcer. All California hospitals performed worse than expected for rates of pneumonia mortality and failure to rescue, but these rates improved throughout the study period and were improving well before the minimum staffing requirements were implemented.

Many of the healthcare leaders we interviewed expressed an expectation that the minimum staffing ratios would raise the quality of care due to increased interaction with patients. However, only a few interviewees felt that the ratios had resulted in such an improvement. Some expressed concern about the break in the continuity of care resulting from maintaining compliance between both the ratios and the meal break rules. Some interviewees reported that the ratios affected patients in their emergency departments. In those hospitals, emergency department waiting times increased, patients occasionally had to be held in the emergency department due to lack staffing, or, in rare cases, the emergency departments were put on diversion so patients had to be transported to other hospitals. Very few hospitals had conducted any analysis of data related to the ratios. While many hospitals conduct regular patient satisfaction surveys, most of the leaders we interviewed said they did not believe there had been a significant change in patient satisfaction as a result of the nurse staffing regulations.

Conclusion

Staffing changes have created challenges and adjustments for some hospitals, particularly with regard to the logistics of meal break compliance and the roles of RNs. The leaders we interviewed did not notice significant changes to the quality of patient care, though emergency departments became bottlenecks at some hospitals. Leaders reported difficulties in absorbing the costs of the ratios, and many had to reduce budgets, reduce services, or employ other cost-saving measures. The interviews did not reveal any important differences in the effects of the ratios upon high-performing and under-performing hospitals.

The minimum nurse staffing regulations did achieve one goal of the legislation: skill mix increased in California hospitals. The hours worked per patient by RNs and registry RNs significantly increased. These improvements in skill mix did not have a clear impact on hospital finances. While overall margins declined between 1999 and 2007, there was no clear relationship between those declines and the start of staffing ratios. This is likely due to other fiscal challenges facing California hospitals. Ratios did not appear to affect most nursing-sensitive outcomes. While the average length of stay changed after 2004, trends in rates of decubitus ulcer, failure to rescue, and deep vein thrombosis, were not changed. More detailed analysis of this and other nursing-sensitive outcomes is needed to fully explore the effect of nurse staffing ratios on the quality of patient care.

Authors

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About the Foundation

The California HealthCare Foundation is an independent philanthropy committed to improving the way health care is delivered and financed in California. By promoting innovations in care and broader access to information, our goal is to ensure that all Californians can get the care they need, when they need it, at a price they can afford. For more information, visit www.chcf.org.

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Institute for Healthcare Improvement Presentation

Tab 9

Why Boards, Why Now? Governance Oversight of Quality

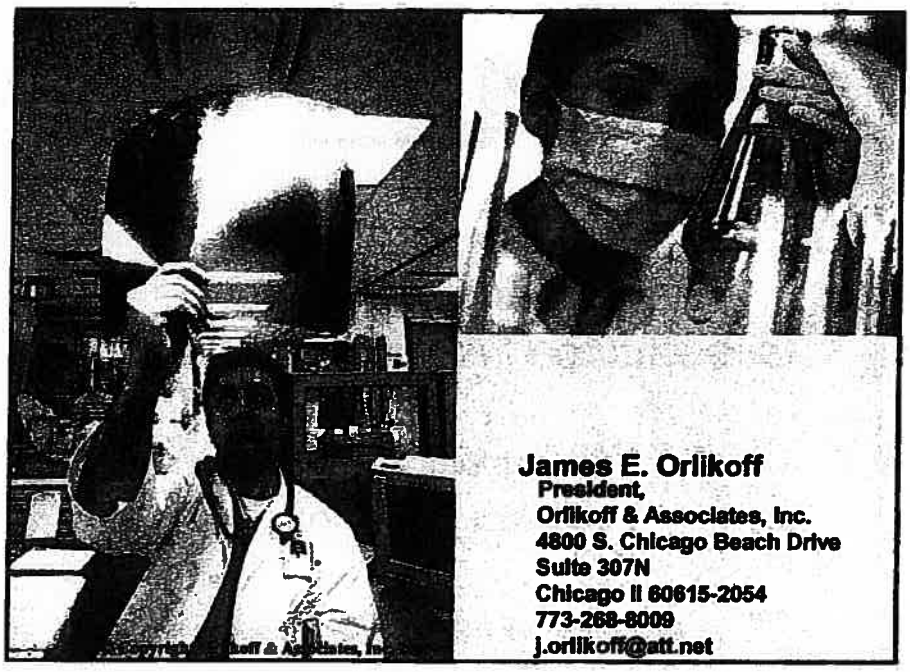
September 29, 2009

James E. Orlikoff

This presenter has nothing to disclose.

Objectives

- After this presentation participants will be able to:
  - —Outline the importance of the role of the board in quality and safety as reflected in recent studies and the personal experience of the faculty.



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"Even small healthcare institutions are complex, barely manageable places... large healthcare institutions may be the most complex organizations in human history."

Peter Drucker

Safety Hazard Probabilities (events per million opportunities)

• Acquiring HIV from 1 unit of transfused blood	0.7
• All heads on 20 coin tosses	1.0
• Death of commercial airline passenger	2.4
• Death: General anesthesia	7.5
• Death: Motor vehicle	187
• Preventable hospital deaths	208

"The great obstacle to progress is not ignorance but the illusion of knowledge."

Daniel Boorstin

Three Big Questions

1. Why does your hospital/system do quality improvement?
2. Does your hospital/system have a definition of quality? What is quality?
3. What can governance and leadership do to improve quality?

What *Is* Quality?

- *"Quality...You know what it is, yet you don't know what it is. But that's contradictory...But when you try to say what quality is, apart from the things that have it, it all goes poof!...If no one knows what it is, then for all practical purposes it doesn't exist at all. But for all practical purposes it really does exist. What else are grades based on? Why else would people pay fortunes for some things and throw others in the trash pile? Obviously some things are better than others...But what's the 'betterness'?*
- *What the hell is quality?*
- *What is it?"*

Robert M. Pirsig
Zen and the Art of Motorcycle *Maintenance*

A Brief History of Quality

The Code of Hammurabi (CIRCA 2,000 B.C.)

"If the surgeon has made a deep incision in the body of a free man and has caused the man's death or has opened the carbuncle in the eye and so destroys the man's eye, they shall cut off his forehand."

I am Called Eccentric for Saying in Public that Hospitals, if They Wish to be Sure of Improvement...

- Must find out what their results are.
- Must analyze their results to find their strong and weak points.
- Must compare their results with those of other hospitals.
- Must care for what cases they can care for well, and avoid attempting to care for cases which they are not qualified to care for well.
- Must welcome publicity not only for their successes, but for their errors, so that the public may give them their help when it is needed.
- Must promote members of the medical staff on the basis which gives due consideration to what they can and do accomplish for their patients.

Such opinions will not be eccentric a few years hence

E.A. Codman, M. D. A study in hospital efficiency, 1916

- The Darling v. Charleston Community Memorial Hospital Case – 1965
- The California Medical Insurance Feasibility Study - 1977
- The Harvard Medical Practice Study - 1991
- The Institute of Medicine Report - 1999

LEGAL RELATIONSHIPS AMONG the BOARD, MANAGEMENT, AND MEDICAL STAFF:

Pre-1965-The Franklin Model

GOVERNING BOARD ← - - - → **MEDICAL STAFF**

(Responsible for Finance, Nonmedical Services, Equipment , and Supplies)

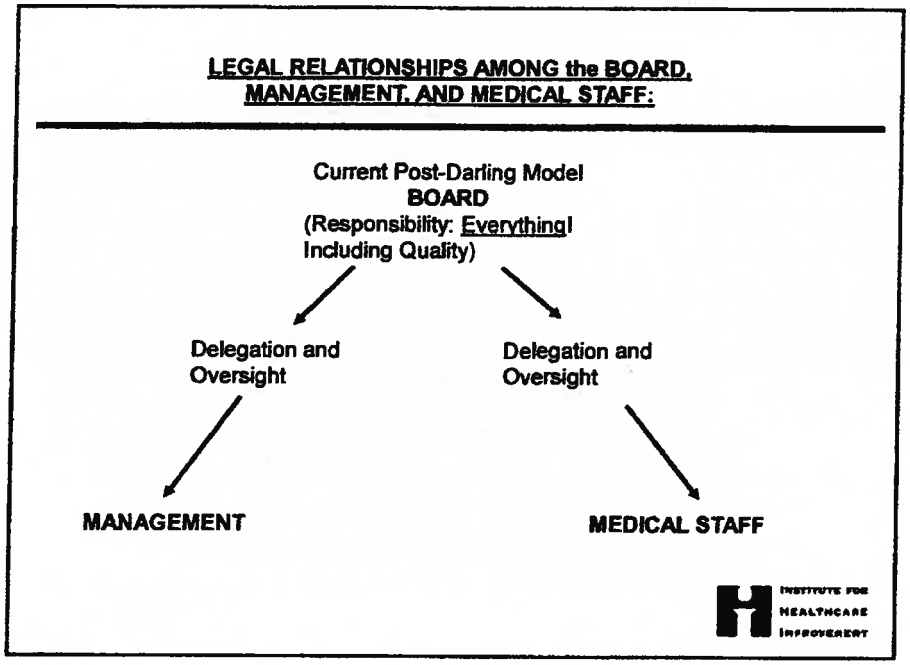
(Responsible for Direct Medical Care, and presumably Quality)

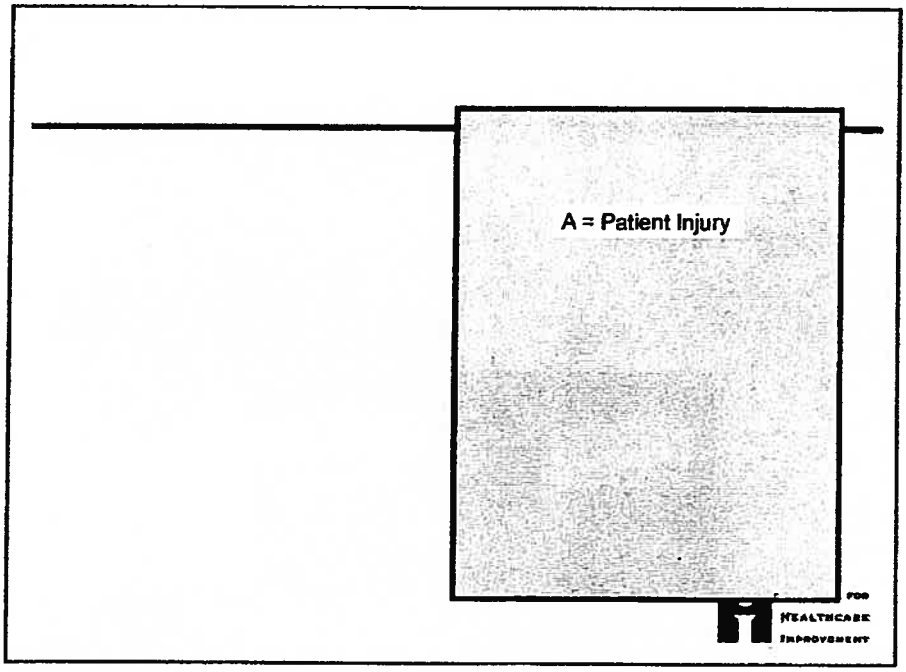
↓

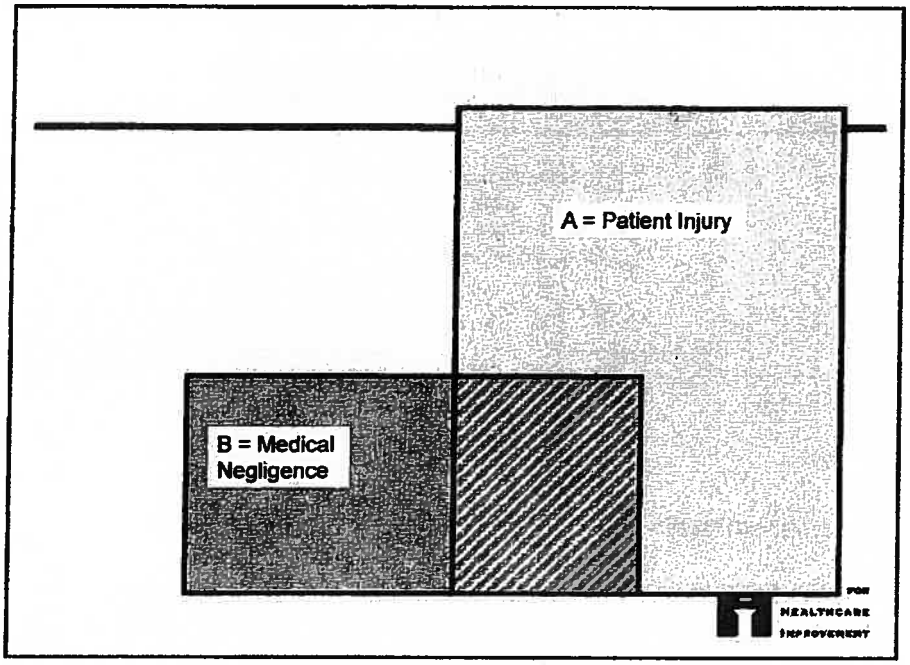
Delegated to

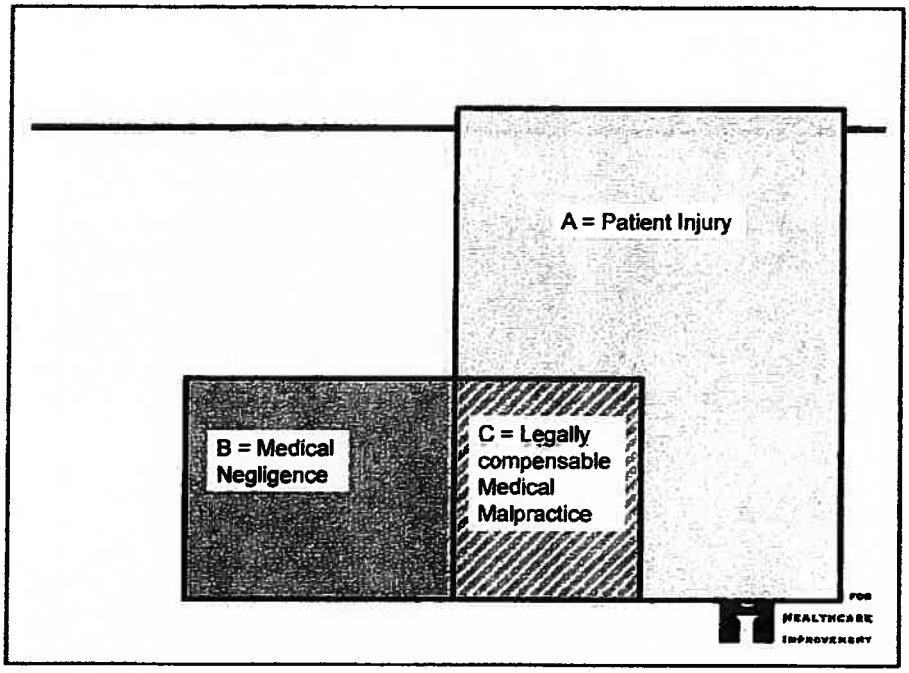
↓

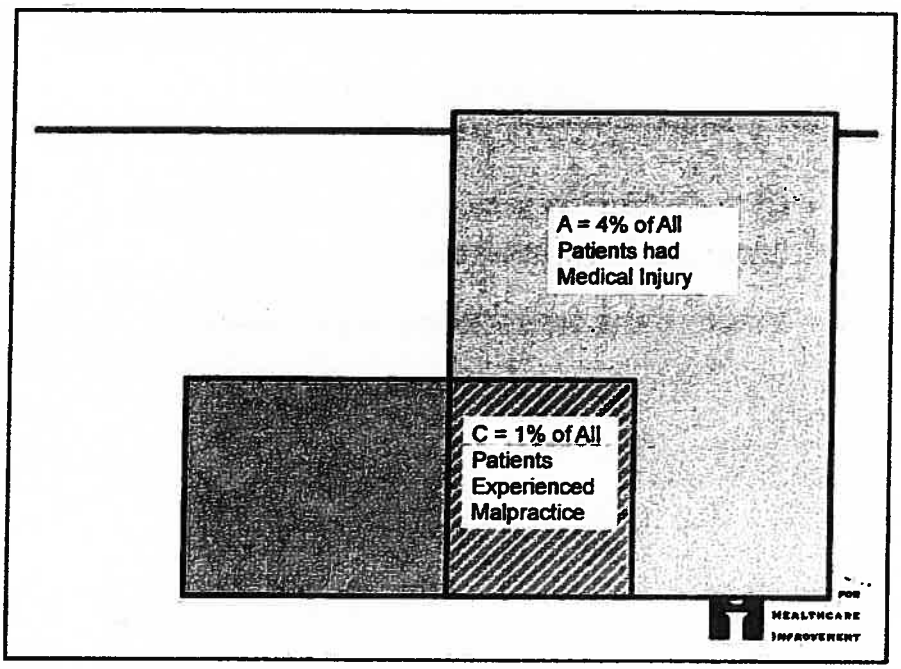
MANAGEMENT

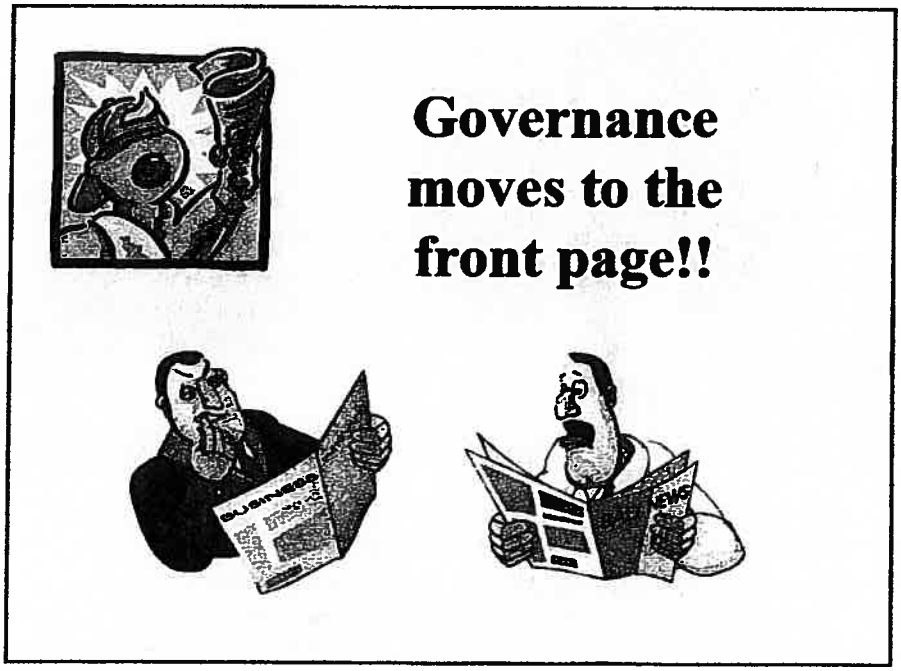

LEGAL RELATIONSHIPS AMONG the BOARD, MANAGEMENT, AND MEDICAL STAFF:
Current Post-Darling Model
BOARD
(Responsibility: Everything! Including Quality)
Delegation and Oversight
Delegation and Oversight
MANAGEMENT
MEDICAL STAFF
INSTITUTE FOR HEALTHCARE IMPROVEMENT


A = Patient Injury
FOR HEALTHCARE IMPROVEMENT


A = Patient Injury
B = Medical Negligence


A = Patient Injury
B = Medical Negligence
C = Legally compensable Medical Malpractice


A = 4% of All
Patients had
Medical Injury
C = 1% of All
Patients
Experienced
Malpractice
HEALTHCARE
IMPROVEMENT


Governance
moves to the
front page!!

But That Doesn't Apply to Hospital Boards, Right?

- In the corporate world, greater calls for financial transparency.
- What is the healthcare equivalent?

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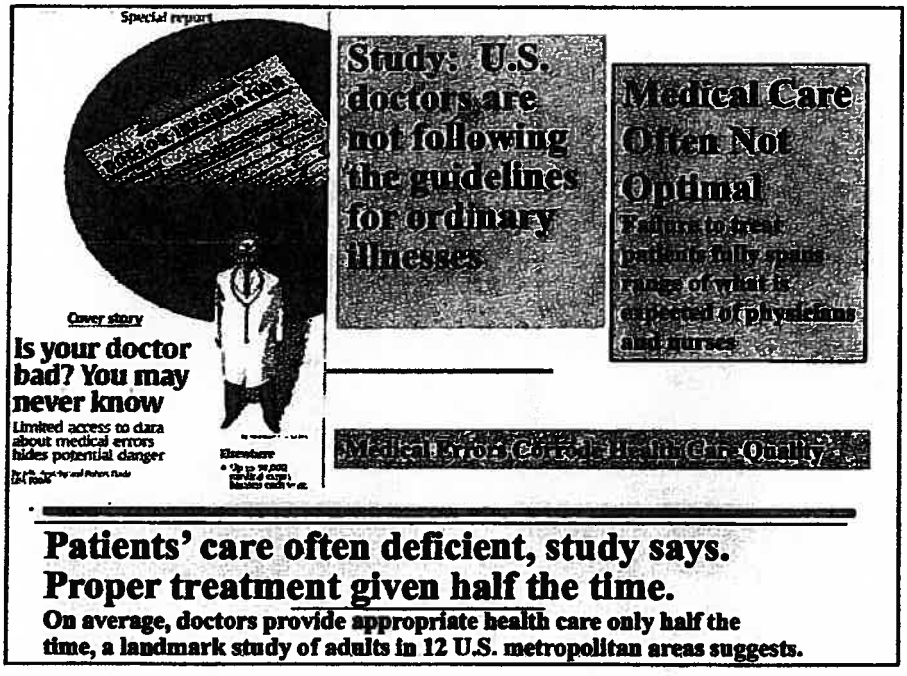

Governance Leadership Focus Continues
Accountability, Improvement, Education

- NQF Safe Practice Revisions: Culture of Safety
  - Extensive focus on boards and C-Suite
- Joint Commission standards updates
  - Governance and leadership; 2009 – Zero Defects
- Office of Inspector General (OIG) of the U.S. Department of Health and Human Services and the American Health Lawyers Association (AHLA),
  - Report: Corporate Responsibility and Health Care Quality
- Statewide initiatives
  - NY: Governor communicates to board chairs
  - MA: BCBSMA links board education to P4P
  - NJ: Legislation mandating board education
  - TN: Voluntary board certification
- Business coalitions
  - National Business Group on Health Toolkit for Action

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HEALTHCARE GOES HIGH PROFILE

Rising healthcare costs are the single-most-pressing fiscal challenge we face by far."

President Barack Obama, February 23, 2009

"If we don't tackle Health Care, then we're going to break the bank."

President Barack Obama, March 6, 2009 –
White House Health Care Summit

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Why?

- Adherence to the status quo
- Misaligned payment incentives
- Inadequate information systems
- Duplicative and costly regulatory oversight
- "Inappropriate balance between autonomy and accountability"

Commonwealth Fund Commission on a High Performance Health System, 2006

10 Years After the IOM "To Err is Human..." Report What Has Changed?

NOT AT *MY* HOSPITAL!

- Patient safety incidents increased by 3% from 2003 to 2005 - Healthgrades Study, 2007
- 67% of physicians have not been involved in collaborative efforts to improve quality – Commonwealth Fund national survey of physicians, 2007
- 46% of physicians failed to report at least one serious medical error, even though 93% of physicians said they should report ALL significant medical errors they observe.
- 45% of physicians did not report impaired or incompetent colleague physicians even though 96% said they should - Annals of Internal Medicine, December 4, 2007

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NEVER EVENTS

WELL...

HARDLY EVER EVENTS

"When Will We Ever Learn??"

"What, never?" "No, never!" "What, never?" "Well, hardly ever!"

Hospital-Acquired Infections: Expensive

- Central line-associated bloodstream infections (CLABs) resulted in an average loss per case of $26,839.
- Costs of CLABs averaged 43% of the total cost of care.
- CLABs resulted in a total loss from operations of $1,449,306 in 54 cases over three years in 2 ICUs.

Shannon RP, Patel B, Cummins D, Shannon AH, Gaspa6, G, Lu Y. Economics of Central-Line Associated Bloodstream Infections. *Am J Med Qual* 2006 Nov-Dec;21(6 Suppl):7S-16S.

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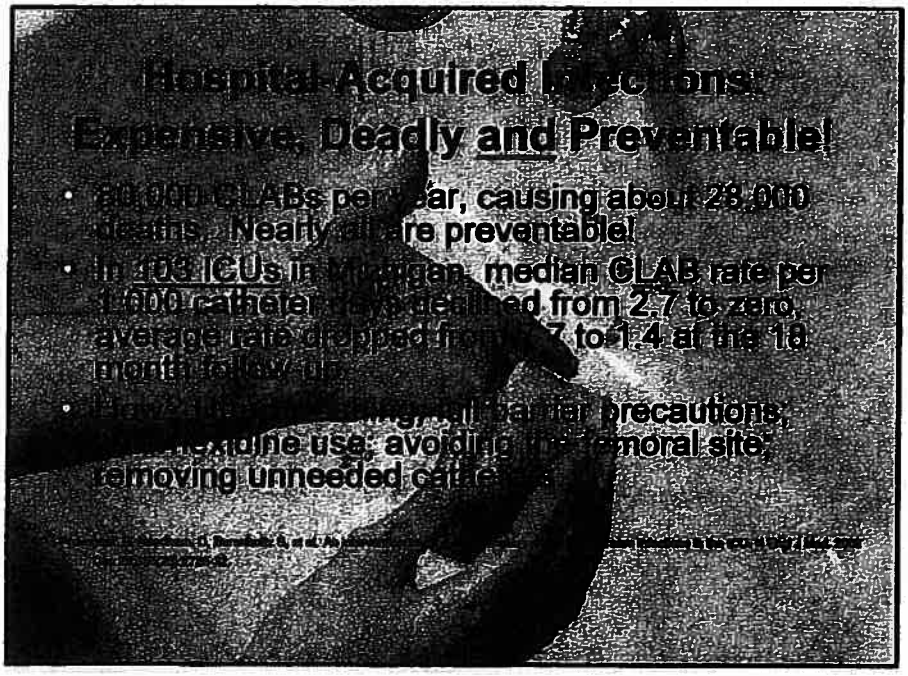


Medicare's Hit List of Never Events

- On October 1, 2008, Medicare changed the way it pays hospitals and health systems for hospital-acquired complications.
  - Hospitals that include a complication code in a DRG must document that the condition was Present on Admission (POA).
  - If Medicare determines that the condition was not POA, or was a result of a mistake in the hospital, the cost of care that is related to that complication will not be reimbursed – and will be borne by the hospital.

MEDICARE'S HIT LIST OF 11 NEVER EVENTS

1. **Air Embolisms**
2. **Mediastinitis – Surgical Site Infection Post CABG (coronary artery bypass graft)**
3. **Catheter-Associated Urinary-Tract Infection (UTI)**
4. **Vascular Catheter-Associated Infections**
5. **Blood Incompatibility**
6. **Objects Left in the Patient During Surgery**
7. **Falls/Trauma**
8. **Pressure Ulcers**
9. **Poorly Controlled Blood Sugar**
10. **Infection after elective orthopedic and bariatric surgery**
11. **Deep vein thrombosis or pulmonary embolism following total hip and knee replacement**

Now Insurers Embrace Never Events

- On April 3, 2008, WellPoint, the nation's largest commercial health insurer, announced it will NOT pay hospitals for 11 preventable errors. These 11 never events include the original list of 8 from Medicare PLUS:
  - —Surgery on the wrong body part
  - —Wrong surgery performed on a patient
  - —Surgery on the wrong patient

Source: WellPoint

Governance and quality…the next *fraud* frontier?

The U.S. Department of Justice Asks

- Has there been a systemic failure by management and the board to address quality issues?
- Has the organization made false reports about quality or failed to make mandated reports?
- Has the organization profited from ignoring poor quality or ignoring providers of poor quality?
- Have patients been harmed by poor quality or given false information?

Governance and quality…the next *criminal* frontier?

Headline: "Death After Two-Hour ER Wait Ruled Homicide"

- Beatrice Vance, 49, died of a heart attack, but the jury at a coroner's inquest ruled that her death also was "a result of gross deviations from the standard of care that a reasonable person would have exercised in this situation."

Vista Medical Center, Waukegan, IL; September, 2006

Headline: "Hospital Changes Procedures After Preemie Deaths"

- September 2006: Three preemies die after they receive adult doses of heparin at Methodist Hospital in Indianapolis.
- "Sam Odle, CEO of Methodist, said a pharmacy technician with more than 25 years experience accidentally took the wrong dosage from inventory and stocked it in the drug cabinet in the Newborn ICU. Nurses, who are accustomed to only one dosage of heparin being available, then administered the wrong dose. The adult and infant doses have similar packaging."

November 2007 Headline:
"Dennis Quaid's Newborn Twins Given 1,000 Times Intended Dose Of Blood Thinner"

- The CMO at Cedars-Sinai Medical Center in LA stated:

  "As a result of a preventable error, the patients' IV Catheters were flushed with heparin from vials containing a concentration of 10,000 units per milliliter instead of from vials containing a concentration of 10 units per milliliter."

July 4, 2008:
It happens again.

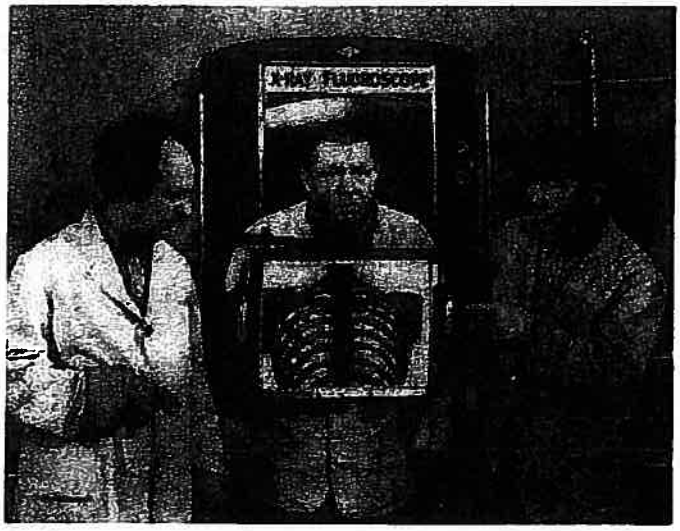
Christus Spohn Hospital,
Corpus Christi, Texas.

17 Premature infants receive adult doses of heparin.

November 2007 Headline: "Hospital Repeats Wrong-Sided Brain Surgery"

- "For the *third time* this year, doctors at Rhode Island Hospital have operated on the wrong side of a patient's head – an action that has brought about censure from the state Department of Health and a $50,000 fine."

HEY, *WHO'S* RUNNING THESE HOSPITALS?!

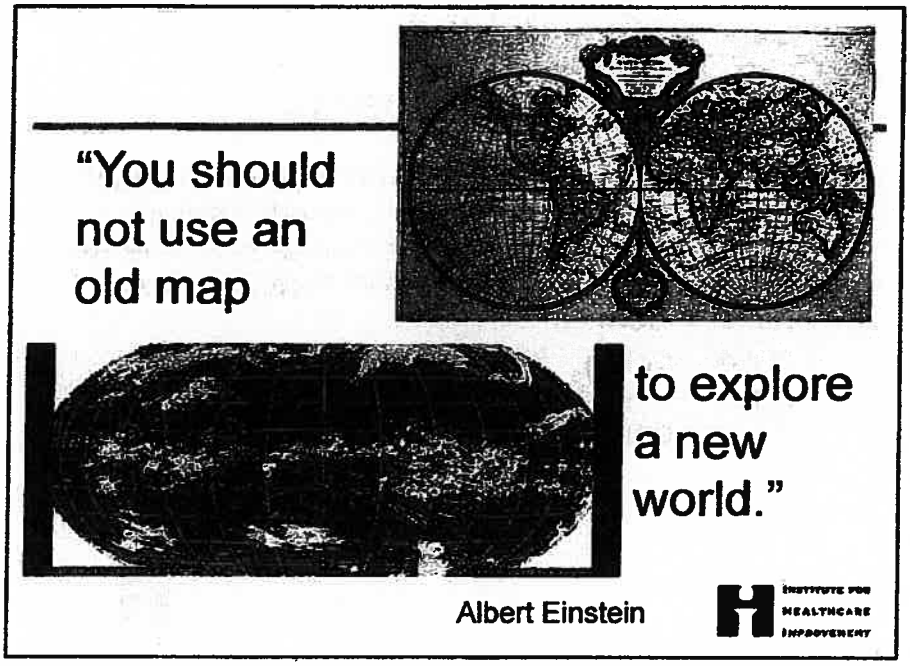


Other Well-Publicized Never Events

- 2004: Radiologist in a Seattle hospital injects chlorhexidine instead of contrast medium directly into a patient's carotid artery. The two solutions were in unmarked containers and looked identical.
- 2008: Urologist in a Minneapolis hospital removes a patient's good kidney, rather than the cancerous one

Board Function ***DOES*** Affect Quality

Emerging research shows that boards can make an enormous difference in improving quality and patient safety.


"You should not use an old map
to explore a new world."
Albert Einstein
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Getting Boards on Board

"What Do the Best Boards Do, and How Do They Do It?"

September 2009

Jim Conway, MS

This presenter has nothing to disclose.

Objectives

- After this presentation participants will be able to:
  - —Share tools provided for "board orientation", focusing specifically on best practices.
  - —Apply learning from selected high performance organizations to their organizations.

Why Do Boards Exist?

To represent the owners

Boards Oversee, on the Owner's Behalf…

- Mission
- Strategy
- Executive leadership
- Financial stewardship
- Quality of care and service

Some Truths About Boards

1. "Hospitals and health care systems are among the most complex business models in the world, but by and large, are governed by well-meaning amateurs." (Orlikoff)
   - No standards or certification for trustees.
   - It isn't just an issue for quality oversight.

Some Truths About Boards

2. Boards think quality is a lot better than the administrators, doctors, and nurses do.
   - "But you never told us in a way we could understand it."
   - "We're above average!"
   - "Mind the gap"

NPSF/AIG Leadership Sessions

Results

- Survey findings obtained from mid-level management participants at each session
  - N=293
- C-Suite findings obtained from Estes Park CEO's and board chairs
  - N=188
- Compared findings from the two groups to identify gaps

Results from NPSF/AIG and Estes Park Survey

	Definitely 1	2	3	4	Not at all 5	
How comfortable are you with your level of engagement safety?	9	37	32	14	7	**% Mgmt**
	4	42	46	6	2	**% Board C-Suite**
Does patient safety trump productivity in your work organization?	9	18	41	20	12	**% Mgmt**
	40	34	20	4	2	**% Board C-Suite**
Are you able to engage your staff in patient safety activities?	13	31	41	13	0	**% Mgmt**
	41	45	12	2	0	**% Board C-Suite**

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Results from NPSF/AIG and Estes Park Survey

	Definitely 1	2	3	4	Not at all 5	
Executive leadership and the board are visibly engaged in patient safety	10	31	36	15	8	% Mgmt
	19	65	14	1	1	% Board C-Suite
Executive leadership provides the tools and training to be effective	9	30	37	17	7	% Mgmt
	14	58	25	2	1	% Board C-Suite
Physician leadership is actively engaged in patient safety efforts	5	18	33	31	12	% Mgmt
	20	48	26	5	1	% Board C-Suite

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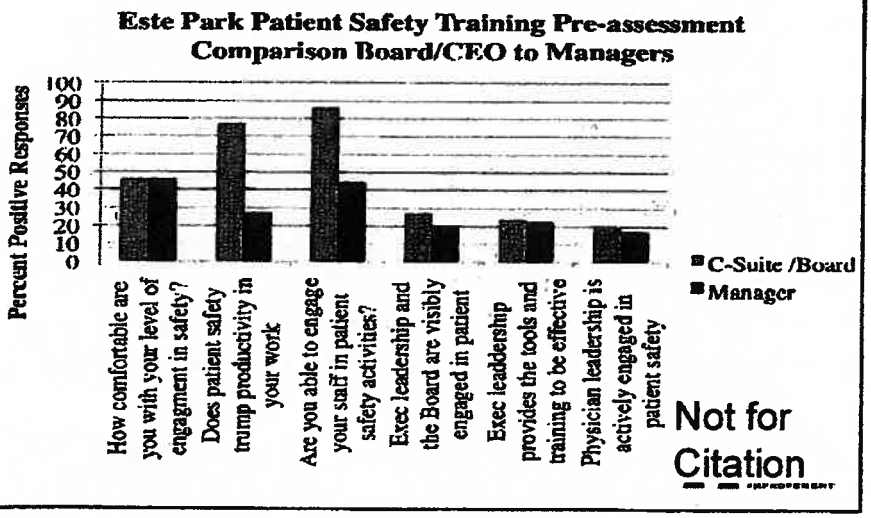
Gaps in Perceptions View of One State



Some Truths About Boards

3. Boards can make an enormous difference.
   - TGI/Solucient Top 100
     - The CEO is held accountable for quality and safety goals.
     - The board participates in the development of explicit criteria to guide medical staff credentialing and privileging.
     - The Board Quality Committee annually reviews patient satisfaction scores.
     - The board sets the board agenda for quality.
     - The medical staff is involved in setting the agenda for the board's discussion surrounding quality.

Lockee, Kroom, Zablocki, Bader, 2006

Better Outcomes Are Associated With Hospitals in Which . . .

- The board spends more than 25% of its time on quality issues.
- The board receives a formal quality performance measurement report.
- There is a high level of interaction between the board and the medical staff on quality strategy.
- The senior executives' compensation is based in part on QI performance.
- The CEO is identified as the person with the greatest impact on QI, especially when so identified by the QI Executive.

Vaughn T, Koepke M, Kroch et. al. 2006

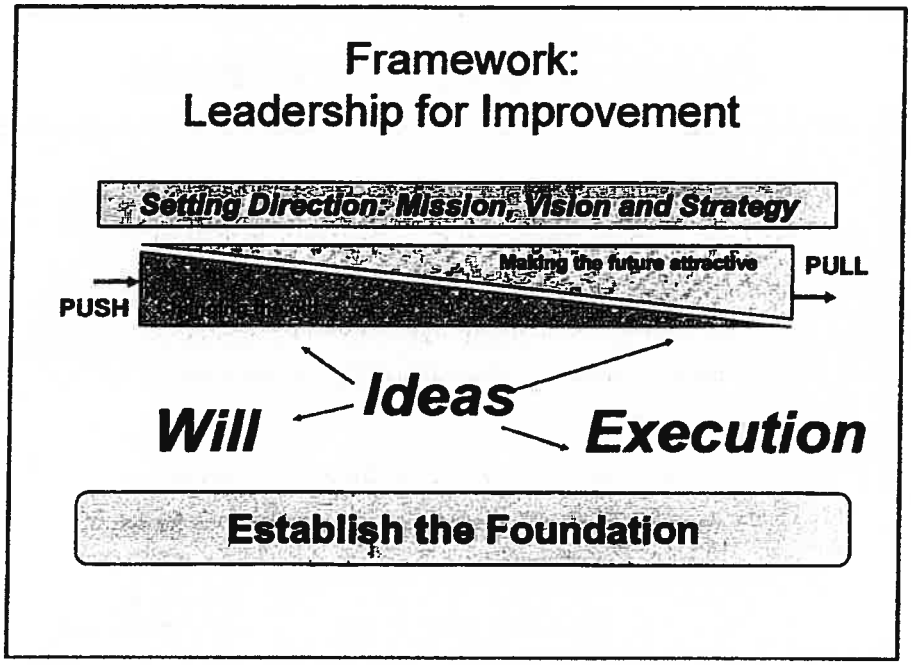
Board Quality Committees

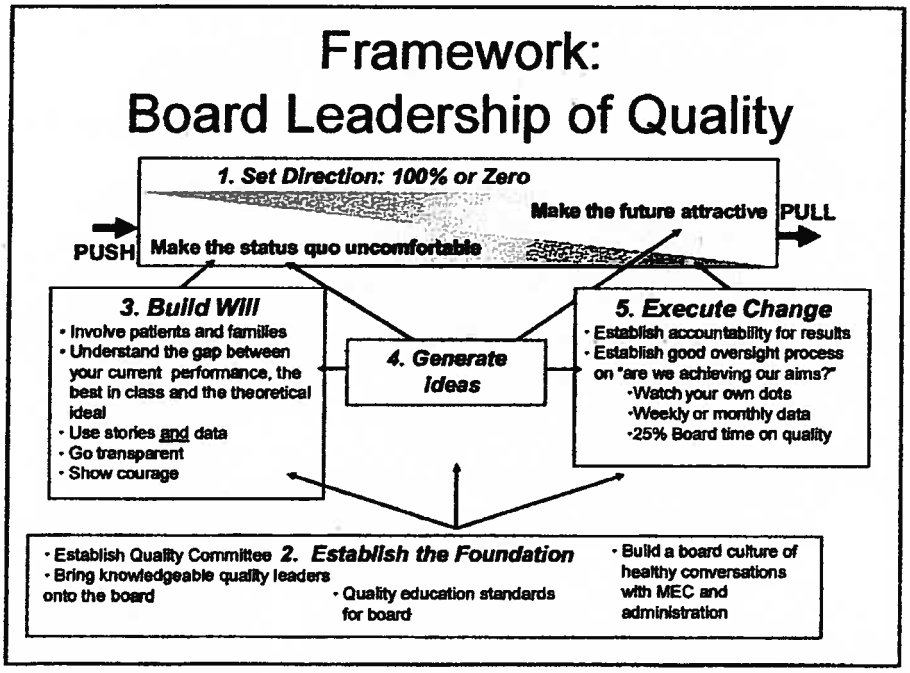
- Hospital governing boards that have a single committee that focuses exclusively or primarily on quality were found to be more likely to adopt various oversight practices and to have better clinical outcomes.
- Only 60% of the responding hospital CEOs confirmed the presence of a Board Quality Committee…

Jiang, Lockee, Bass, Fraser. 2008

Some Truths About Boards

4. If you've seen one board, you've seen one board.
   - How members are chosen
   - Open/closed meetings
   - 6-150 members
   - System and unit boards
   - Cultures and patterns of dialog
   - Levels of engagement and capability


Framework:
Leadership for Improvement
Setting Direction: Mission, Vision and Strategy
Making the future attractive
PUSH
PULL
Will
Ideas
Execution
Establish the Foundation


Framework:
Board Leadership of Quality
1. Set Direction: 100% or Zero
Make the future attractive
PULL
PUSH
Make the status quo uncomfortable
3. Build Will
• Involve patients and families
• Understand the gap between your current performance, the best in class and the theoretical ideal
• Use stories and data
• Go transparent
• Show courage
4. Generate Ideas
5. Execute Change
• Establish accountability for results
• Establish good oversight process on "are we achieving our aims?"
•Watch your own dots
•Weekly or monthly data
•25% Board time on quality
• Establish Quality Committee
• Bring knowledgeable quality leaders onto the board
2. Establish the Foundation
• Quality education standards for board
• Build a board culture of healthy conversations with MEC and administration

Specific Aims Adopted by Boards

- "BIDMC and BID-Needham will eliminate all preventable harm by January 1, 2012."

  BIDMC Board Resolution

- "We will achieve an 80% reduction in harm to our patients in 3 years, as measured by Serious Safety Event Rate."

  Sentara

- "We will achieve a 50% reduction in hospital-acquired infections within 12 months, as measured by the sum of Central Line Bloodstream Infections, Ventilator-Acquired Pneumonias, and Catheter-Associated Urinary Tract Infections."

  WellStar Health System

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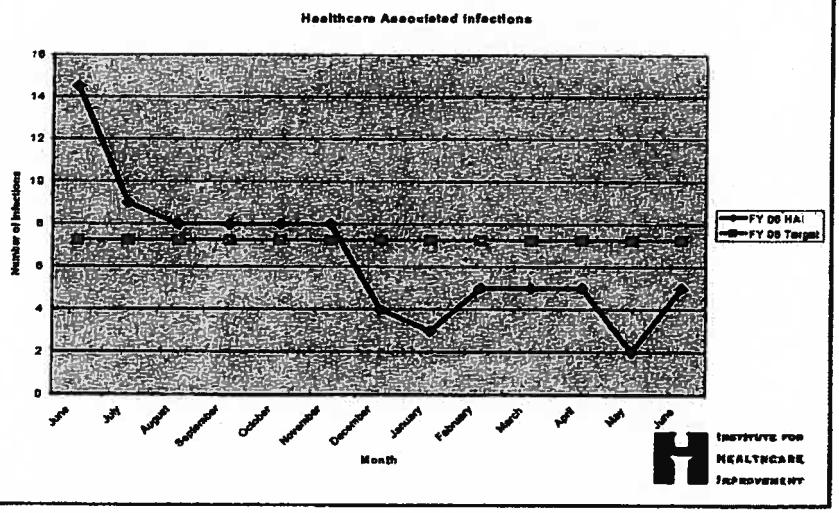
WellStar: FY 08 Healthcare Associated Infections



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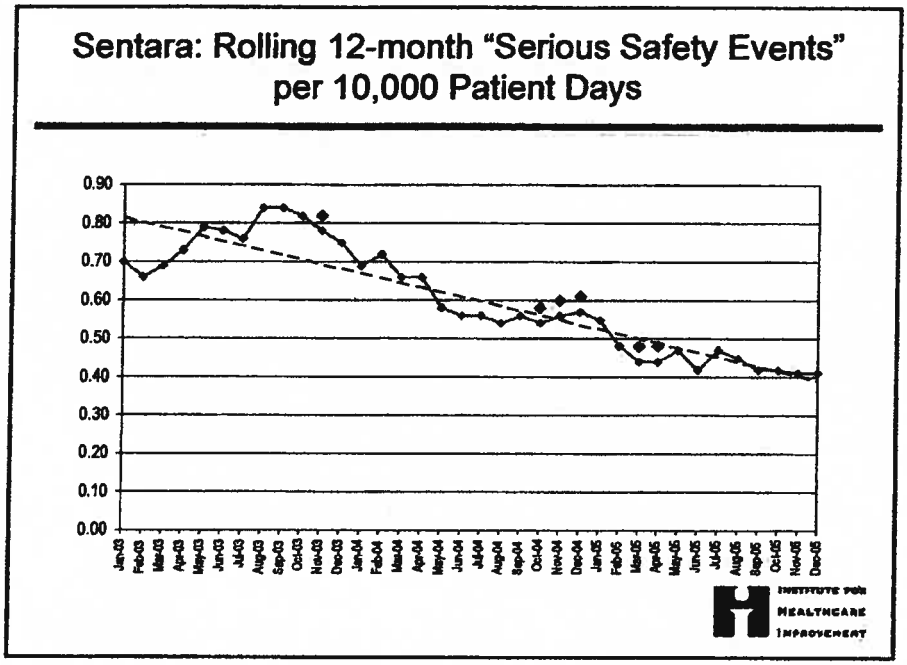
Sentara: Rolling 12-month "Serious Safety Events" per 10,000 Patient Days
0.90
0.80
0.70
0.60
0.50
0.40
0.30
0.20
0.10
0.00
Jan-03
Feb-03
Mar-03
Apr-03
May-03
Jun-03
Jul-03
Aug-03
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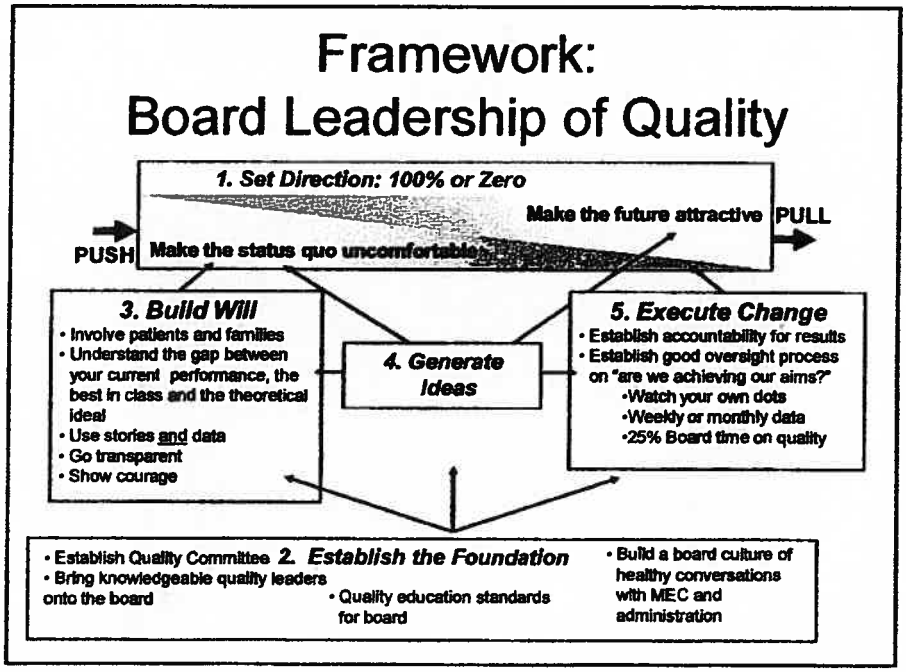
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Functions of a Board Quality Committee

- Recommend annual quality and safety aims to the board
- Integrate the patient and family into the committee
- Oversee achievement of quality and safety aims
- Oversee credentialing process integrity and reliability
- Oversee compliance with quality/safety regulatory requirements
- Recommend new/improved quality and safety policies to the full board for adoption, as needed
- Signal to management and medical staff desired quality and safety culture in the organization
- Build the team and provide locus for crucial conversations among board, executive and clinical leaders

Reinertsen and others

Trustee-Basic Agenda Board Quality Committee

- Begin with a brief story of a patient experience
- Review the major quality and safety aims for the year, and the current "strategic dashboard" on performance toward those aims.
- Review sentinel events and reports of harm
- Review the "regulatory dashboard" for any exceptions—anything that is falling out of compliance, and hear the plan for getting back into compliance
- Consider any policy recommendations that need to be brought to the full Board, and vote on them
- Review the meeting itself. Did we talk about the important things? Did everyone get a chance to be heard? What could we improve?

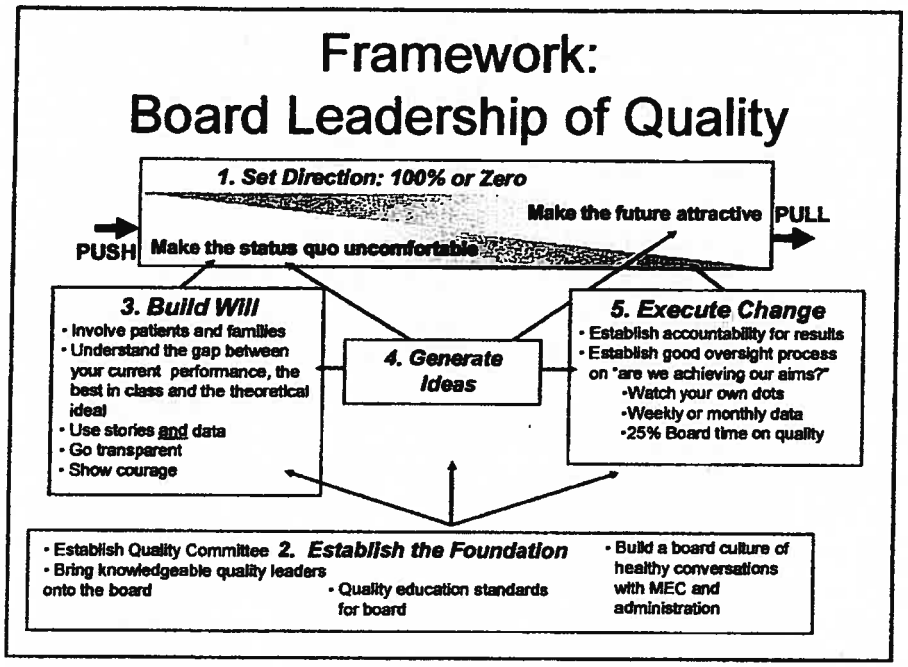
Reinertsen, Conway, others

Board Quality Committee Report to the Full Board

- Every board meeting
- First item on agenda
- Assume 25% of board time
- Trustee leads with management support.
- Always use language that allows trustees to apply their personal learning.
- Review the big dots in simple language.
- Highlight key issues that the committee is dealing with.
- Solicit feedback and questions.
- Make recommendations for policy changes.

Board Core Curriculum Answers the Following Questions

- What is the board of trustees' responsibility and accountability for quality and safety?
- What is the current state of quality improvement and safety in health care overall, in your community, and in your hospital? How does prevailing practice stand up to best practice?
- How can board members effectively leverage their roles and experiences to affect the pace of quality improvement in their organization?
- What are the best strategies to sustain the gain and drive continuous improvement?



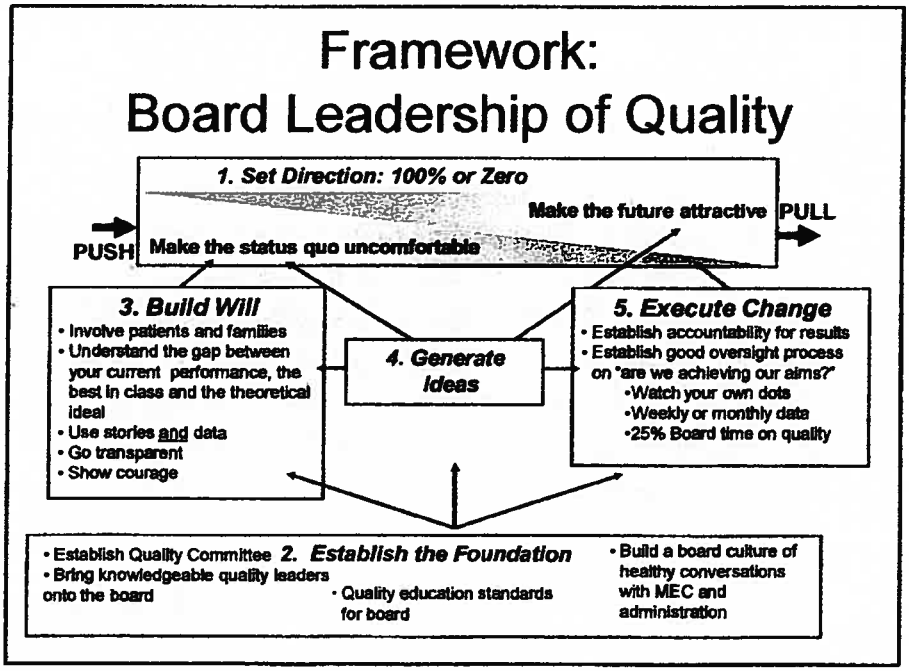
"Findings…dashboards are generally used to create general awareness rather than used to guide operations and performance management…Greater hospital quality was linked to shorter, more focused dashboards, active use of dashboards for operations management, and strong influence of board quality committees in dashboard content and implementation."

Kroch et al., Journal of Patient Safety 2 (1) 10-19, March 2006

Options: Involving Patients and Families with Boards of Trustees

- Showing video of "an infection": Ginny's Story YouTube
  - "Meet my friend Ginny"
- CEO interviews of patients / families reported to Board
  - Recent admissions or serious preventable event
- Inviting patients and families to share there experiences of care as part of a board retreat
- Making a video of a patient / family interview and show it at the board meeting.
- Inviting patients and families to the Board meeting to share their experiences
- Inviting patients / families on Board Quality Committee
- Inviting trustees to interact with patients on wa[illegible]urds

Framework: Board Leadership of Quality



What Questions Should the Board Be Asking?

- Organizations are coming up with them
  - —Providence Health and Systems
- Health lawyers and the Office of the Inspector General are too!
  - —AHLA and OIG suggestions (appendix)
- Boards role in generative thinking
  - —It isn't about reviewing every incident
  - —Richard Chait et.al.

Management & Governance Quality
Providence Health & Systems Questions

Wise Strategic Thinking

- **Question 1** – Are we clear about our quality strategic aims and focused on the most important improvement opportunities to achieve those aims?
- **Question 2** – Is there a solid strategic rationale for the annual and long term improvement goals that management is recommending?

Focused & Effective Execution

- **Question 3** – Are we improving fast enough to meet our annual and long term improvement goals?
- **Question 4** – Do we have any systemic weaknesses that should be addressed to meet our internal improvement aims and/or to respond to external demands for data and accountability?
- **Question 5** – Are there any individual facilities or programs that have weak improvement capabilities or insufficient capacity to improve?

Question 6 – What are our experiences with improvement telling us about the changes that are necessary in our Quality Strategic Plan? (***widespread learning***)

Question 7 – Are we sparking ***Innovation***, finding and systematically spreading best outcome practices and great ideas?

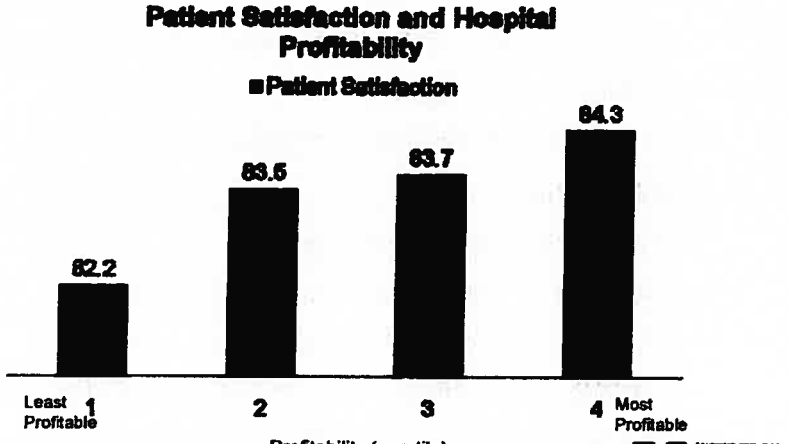
Hot Topics:

- Dashboards
- Involving patients and families
- Engaging physicians
- System level boards
- Public boards
- Rural and critical access hospitals
- Governance and leadership assessment
- Professional practice / disruptive behaviors
- Forming a quality committee of the Board
- Serious reportable events / never events
- Linking outcomes; quality, cost, satisfaction

Does Improving Safety Save Money? Henry Ford Health System

IMPROVEMENT	COST	SAVINGS	NET
SURGICAL INFECTIONS	($110,000)	$540,000	$430,000
BLOODSTREAM INFECTIONS	($22,500)	$4,780,000	$4,757,500
VENTILATOR PNEUMONIAS	($0)	$1,166,400	$1,166,400
RAPID RESPONSE TEAMS	($390,000)	?	($390,000)
TOTAL	($522,500)	$6,486,400	$5,963,900

Research conducted by Press Ganey – hospitals divided into quartiles based on their profitability, with the patient satisfaction scores then averaged for each quartile.



Source: Hall M, "Looking to improve financial results? Start [illegible] patients," *Healthcare Financial Management*. October, 2008.

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Allegheny General Hospital Reduction in HAI in CCU/MICU:

Return on Investment

- Total Operating Improvements
  - CLAB= $1,235,765 (2 years)
  - VAP= $1,003,162 (1 year)
  - MRSA= $ 295,342 (1 year)
- Highmark PFP = $3,100,000 (2 years)
- HAI elimination Initiatives = +$5,634,269
- Investment = $85,607
- 388 additional ICU admissions
- 57 lives saved

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Lengthen the Chain to Reduce Length of Stay

- University of Pittsburgh Medical Center (UPMC) redesigned care for patients undergoing total joint replacement.
- New Design:
  - —Pre-op testing, teaching
  - —Coaching meetings with other patients
  - —Pre-surgery discharge planning
  - —Strong focus on complete pain management
  - —"Wellness" design in orthopedics unit

DiGioia A, Greenhouse P, Levison T. "Patient and Family-centered Collaborative Care: An Orthopaedic Model". *Clinical Orthopaedics and Related Research*. 2007: 463; pp: 13-19.

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UPMC Results

- Average length of stay:
  - —2.8 days for TKA (national average is 3.9 days)
  - —2.7 days for THA (national average is 5.0 days)
- Mortality rates: 0.1% (0.2% for TKA and 0% for THA)
- Infection rates: 0.3% (0% for TKA and 1.0% for THA)
- 91% of patients discharged without handheld assistance directly to home (national rates: 23-29%)

DiGioia A, Greenhouse P, Levison T. "Patient and Family-centered Collaborative Care: An Orthopaedic Model". *Clinical Orthopaedics and Related Research*. 2007: 463; pp: 13-19.

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Example: Optimizing Your ICU

- Intermountain Healthcare
  - —60% reduction in ventilator time
  - —Resulted in a 30% reduction in thoracic ICU length of stay
  - —15% reduction in the total costs of performing open-heart surgery
    - ➢(~$3,000 per patient; or net of $5.5 million per year, system-wide).

Brent James, Intermountain Healthcare

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Boards on Board Plank
5 Million Lives Campaign

1. Setting aims
   - — Set a specific aim to reduce harm this year.
   - — Make an explicit, public commitment to measurable quality improvement.

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Boards on Board Plank
5 Million Lives Campaign

2. Getting data and hearing stories
   - Select and review progress toward safer care as the first agenda item at every board meeting.
   - Ground the work in transparency, putting a "human face" on harm data.
   - Engage with patients and families.
   - Tools: chart audit; case study of a specific case

Board on Board Elements

3. Establishing and monitoring system-level measures
   - Identify a small group of organization-wide "roll-up" measures of patient safety.
   - Continually update them.
   - Make them transparent to the entire organization and all of its customers.

Board on Board Elements

4. Changing the environment, policies, and culture
   - Commit to establish and maintain an environment that is respectful, fair and just for all who experience the pain and loss as a result of avoidable harm and adverse outcomes: the patients, their families, and the staff at the sharp end of error.

Board on Board Elements

5. Learning
   - —Starting with the board, develop your capability as a board.
   - —Set an expectation for similar levels of education and training for all staff.

Board on Board Elements

6. Establishing executive accountability
   - —Oversee the effective execution of a plan to achieve your aims to reduce harm.
   - —Include executive team accountability for clear quality improvement targets.

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5 Million lives

To do things differently, we must see things differently. When we see things we haven't noticed before, we can ask questions we didn't know to ask before.

John Kelsch, Xerox
Quality Health Care In America Project

Resources

- IHI Web Information: www.ihi.org
  - Updated How-to-Guide posted March 1, 2008
- Joint Commission Journal on Quality and Patient Safety
  - Conway J. April, 2008
  - 5 Million Lives Campaign, Getting Boards on Board: Engaging Governing Boards in Quality and Safety,

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Appendix

Set Direction: Promises and Aims

- We will offer *all and only* what we know will help you.
  - —The aim is 100%.
- We will do *nothing* that will harm you.
  - —The aim is zero.
- Ascension Health
  - —Healthcare that is safe
    - ➢ No preventable injuries or death by July 2008
  - —Healthcare that works
  - —Healthcare that leaves no one behind

The Best Boards…

- Aim high
  - —"Our aim is to achieve zero central line infections…"
- Aim broad
  - —"…for the entire institution, across all services…"
- Take dead aim
  - —"…by August 31, 2008."

Build the Foundation

- Establish a Quality Committee of the Board.
- Bring quality expertise onto the board.
- Set/achieve educational standards for board.
- Build a culture of real conversations.
  - — At board and committee meetings
  - — With physician leaders
  - — With administration
- Allocate adequate resources for all staff training.

Build Will

- Establish a policy of full data transparency.
- Insist on data *and* stories.
- Help/let patients and families tell their stories.
- Set the expectation.
  - — Communication, disclosure, support, resolution, learning
- Understand the gap between current performance and ideal/best in class.
- Give quality and safety 25% of the board's time.
- Show courage: don't flinch.

Drive Execution

- Establish accountability for achievement of aims.
- Establish an effective oversight process.
  - —25% of board time on quality and safety
  - —Watch your own dots.
  - —Weekly or monthly data
- Ask hard questions.
  - —Are we on track to achieve the aim?
  - —If not, why not? Strategy? Execution?

OIG and AHLA
Key Questions for Hospital Board

1. What are the goals of the organization's quality improvement program? What metrics and benchmarks are used to measure progress towards each of these performance goals? How is each goal specifically linked to management accountability?
2. How does the organization measure and improve the quality of patient/resident care? Who are the key management and clinical leaders responsible for these quality and safety programs?
3. How are the organization's quality assessment and improvement processes integrated into overall corporate policies and operations? Are clinical quality standards supported by operational policies? How does management implement and enforce these policies? What internal controls exist to monitor and report on quality metrics?

OIG and AHLA
Key Questions for Hospital Board

4. Does the board have a formal orientation and continuing education process that helps members appreciate external quality and patient safety requirements? Does the board include members with expertise in patient safety and quality improvement issues?
5. What information is essential to the board's ability to understand and evaluate the organization's quality assessment and performance improvement programs? Once these performance metrics and benchmarks are established, how frequently does the board receive reports about the quality improvement efforts?
6. How are the organization's quality assessment and improvement processes coordinated with its corporate compliance program? How are quality of care and patient safety issues addressed in the organization's risk assessment and corrective action plans?

OIG and AHLA
Key Questions for Hospital Board

7. Are human and other resources adequate to support patient safety and clinical quality? How are proposed changes in resource allocation evaluated from the perspective of clinical quality and patient care? Are systems in place to provide adequate resources to account for differences in patient acuity and care needs?
8. Do the organization's competency assessment and training, credentialing, and peer review processes adequately recognize the necessary focus on clinical quality and patient safety issues?
9. How are "adverse patient events" and other medical errors identified, analyzed, reported, and incorporated into the organization's performance improvement activities? How do management and the board address quality deficiencies without unnecessarily increasing the organization's liability exposure?

American Health Lawyers Association, Annual Meeting June 25-27, 2007, CORPORATE RESPONSIBILITY AND HEALTH CARE QUALITY: A RESOURCE FOR HEALTH CARE BOARDS OF DIRECTORS, Wednesday, June 27, 2007, Arianne N. Callender, Douglas A. Hastings, Michael C. Hemsley, Lewis Morris, Michael W. Peregrine

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Boards and Dashboards

September 2009

James L. Reinertsen, MD

This presenter has nothing to disclose.

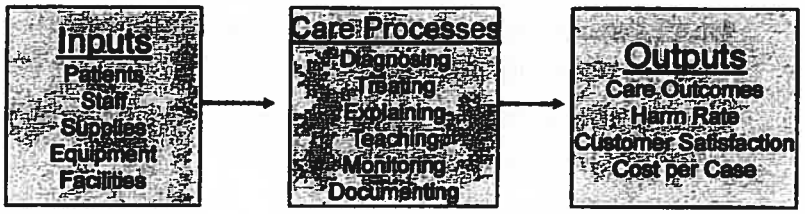
Objectives

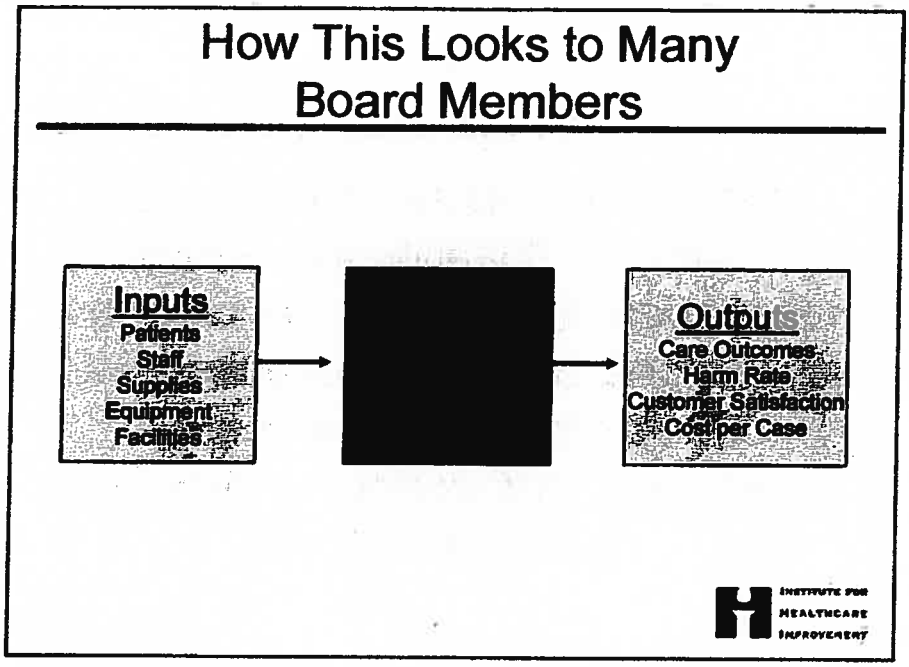
- After this presentation participants will be able to:
  - —List two questions boards should ask about quality performance data.
  - —Describe three best practices for use of board quality and safety dashboards.

Exercise

- Examine your organization's dashboard:
  - Are your major aims crystal clear on the dashboard? (test: ask a lay board member to explain the quality aims in one or two sentences)
  - How timely are the measures on the dashboard? Why does it take so long to get the data?
  - For harm-related measures, does the dashboard answer the question "How many patients were harmed?"

A Health Care System's Core Work




How This Looks to Many Board Members
Inputs
Patients
Staff
Supplies
Equipment
Facilities
Outputs
Care Outcomes
Harm Rate
Customer Satisfaction
Cost per Case
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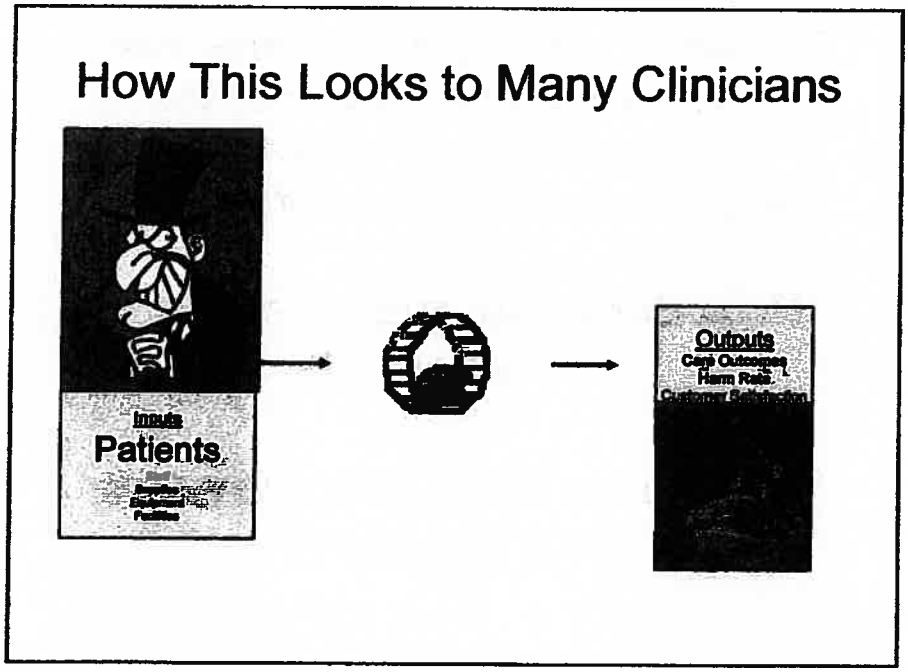

How This Looks to Many Clinicians
Patients
Outputs

Many lay Trustees have trouble with the "Quality and Safety Dashboard," and one main reason is that the dashboard contains a lot of detailed "process of care" measures that doctors understand, but bankers don't.

The other main reason is that many dashboards mix together the answers to two questions that boards should ask about quality:

"How does our quality compare to others?"

"Are we on track to achieve our quality aims?"

Trustees (Non Exec Directors) Often Ask....

- "Our dashboard has 47 different measures on it. How do I know which ones are important?"
- "I don't understand half the items on the dashboard. So how can I ask any hard questions?"
- "Can you tell us what should be on our dashboard?"
- ***What are <u>your</u> questions about dashboards?***

Seven Leverage Points:

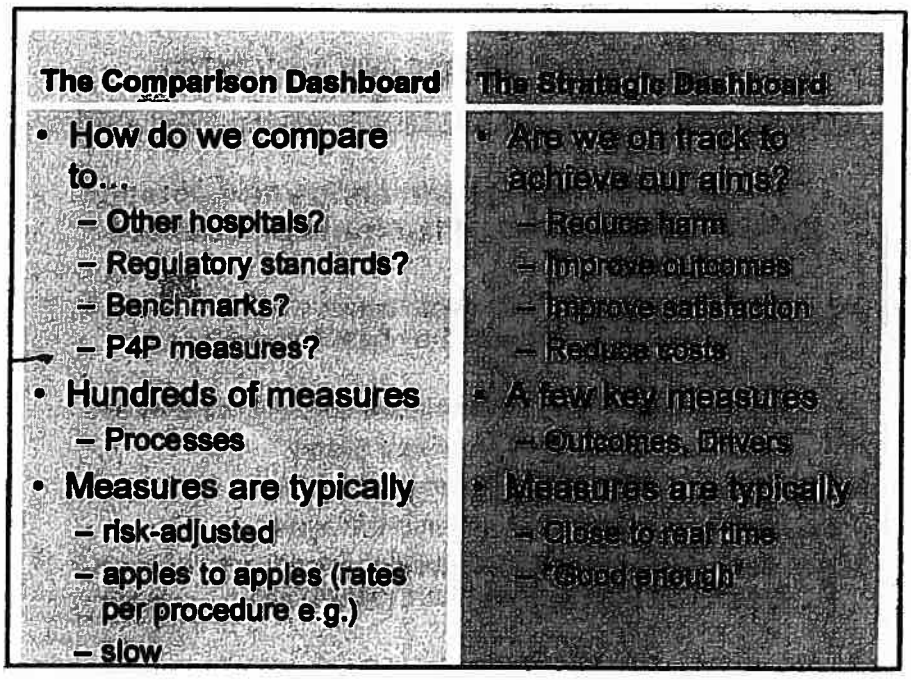
<u>Places to Start, if You Want to Achieve System-Level Results...</u>

1. **Set specific system-level aims and oversee their achievement at the highest levels of governance.**
2. Build an <u>executable</u> strategy to achieve the aims, and oversee the execution at the highest levels of administration.
3. Channel attention to system-level aims and measures.
4. Get patients and families on your team!
5. Engage the CFO in achieving the aims.
6. Engage physicians in achieving the aims.
7. Build the improvement capability necessary to achieve the aims, at every level of the organization.

"Findings…dashboards are generally used to create general awareness rather than used to guide operations and performance management…Greater hospital quality was linked to shorter, more focused dashboards, active use of dashboards for operations management, and strong influence of board quality committees in dashboard content and implementation."

Kroch et al., Journal of Patient Safety 2 (1) 10-19, March 2006

pay for performance



Examples: Strategic Safety Aims

- "Beth Israel Deaconess Medical Center will eliminate all preventable harm by January 1, 2012."

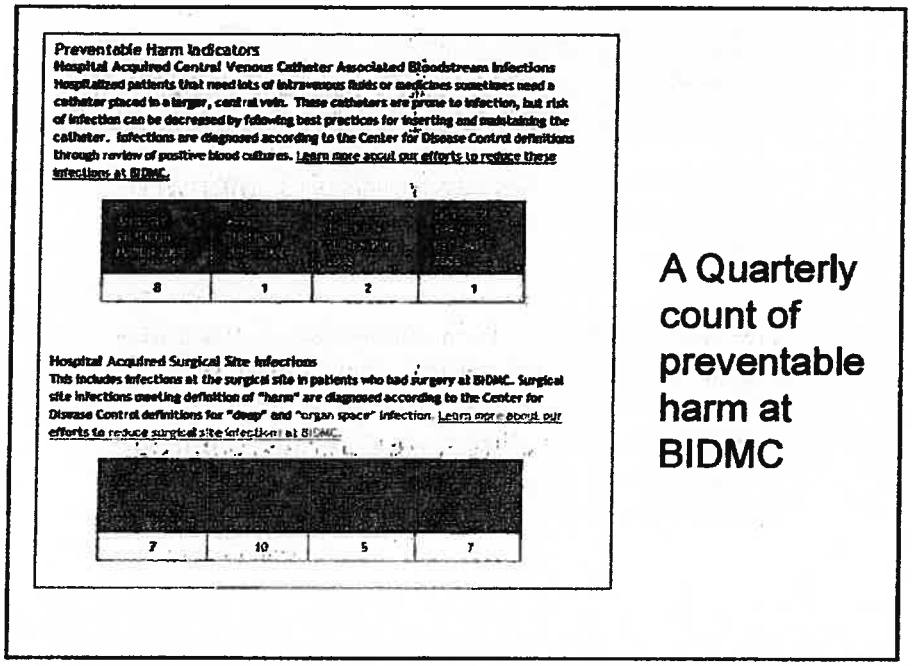
www.bidmc.harvard.edu

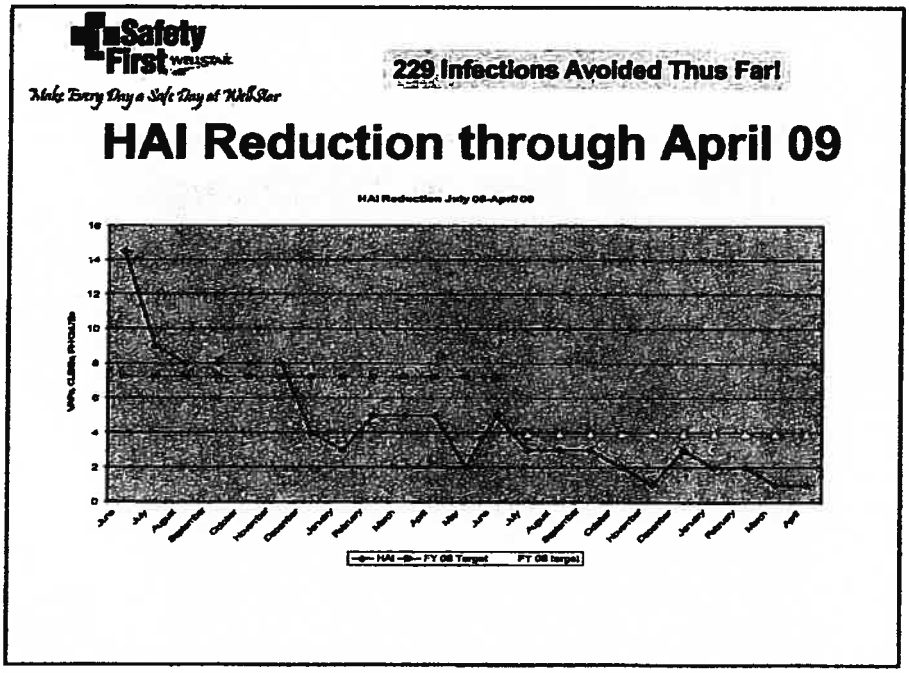
- "We will achieve a 50% reduction in hospital-acquired infections within 12 months, as measured by the sum of Central Line Bloodstream Infections, Ventilator-Acquired Pneumonias, and Catheter-Associated Urinary Tract Infections."

WellStar Health System

The lead item on the strategic safety dashboard answers the question:

"Are we on track to achieve our aim?"


Preventable Harm Indicators
Hospital Acquired Central Venous Catheter Associated Bloodstream Infections
Hospitalized patients that need lots of intravenous fluids or medicines sometimes need a catheter placed in a larger, central vein. These catheters are prone to infection, but risk of infection can be decreased by following best practices for inserting and maintaining the catheter. Infections are diagnosed according to the Center for Disease Control definitions through review of positive blood cultures. Learn more about our efforts to reduce these infections at BIDMC.
8
1
2
1
Hospital Acquired Surgical Site Infections
This includes infections at the surgical site in patients who had surgery at BIDMC. Surgical site infections meeting definition of "harm" are diagnosed according to the Center for Disease Control definitions for "deep" and "organ space" infection. Learn more about our efforts to reduce surgical site infections at BIDMC.
7
10
5
7
A Quarterly count of preventable harm at BIDMC


Safety First
Make Every Day a Safe Day at NeighborLink
229 Infections Avoided Thus Far!
HAI Reduction through April 09
HAI Reduction July 08-April 09
14
12
10
8
6
4
2
0
HAI
FY 08 Target
FY 08 target

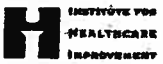
Not-So-Specific Aims

- "Our hospital strives to achieve the highest levels of quality"
- "Memorial General aims to be in the top tier of hospitals for quality and safety"

As measured by....?

By when...?

Murky aims beget murky dashboards.

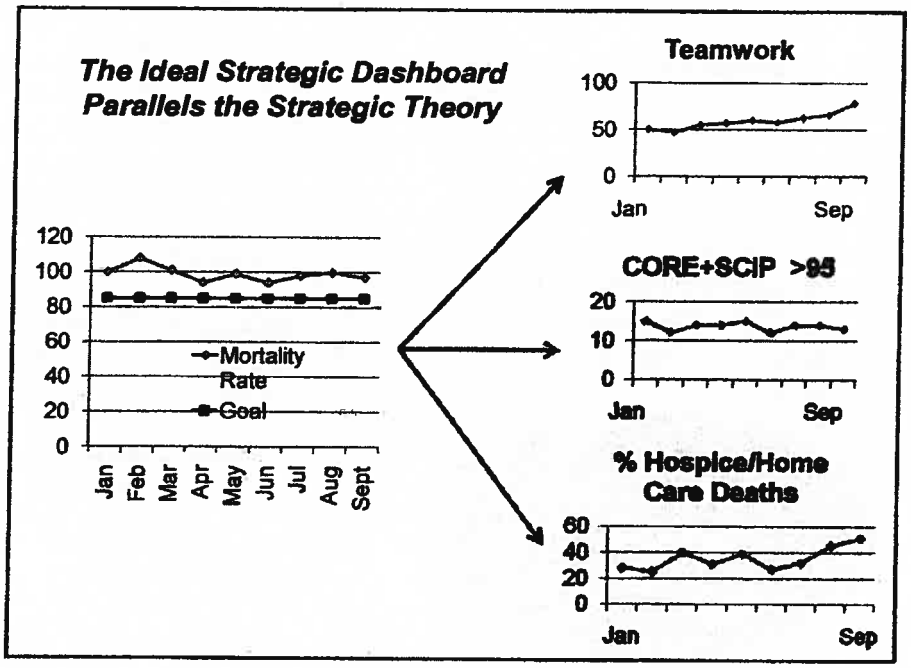


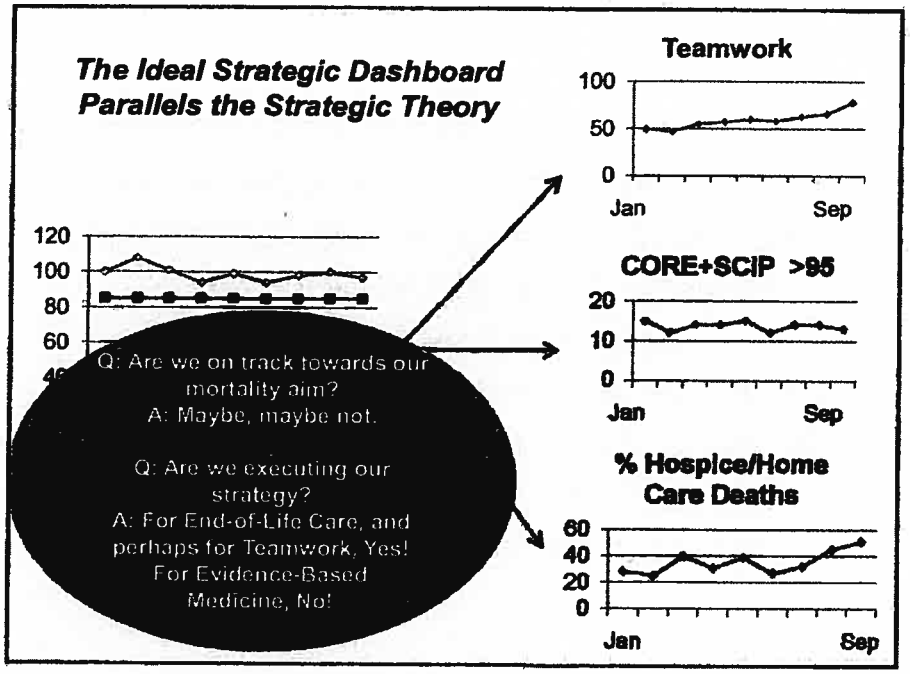
Your Strategic Theory Drives the Creation of the Board "Strategic Quality Dashboard"

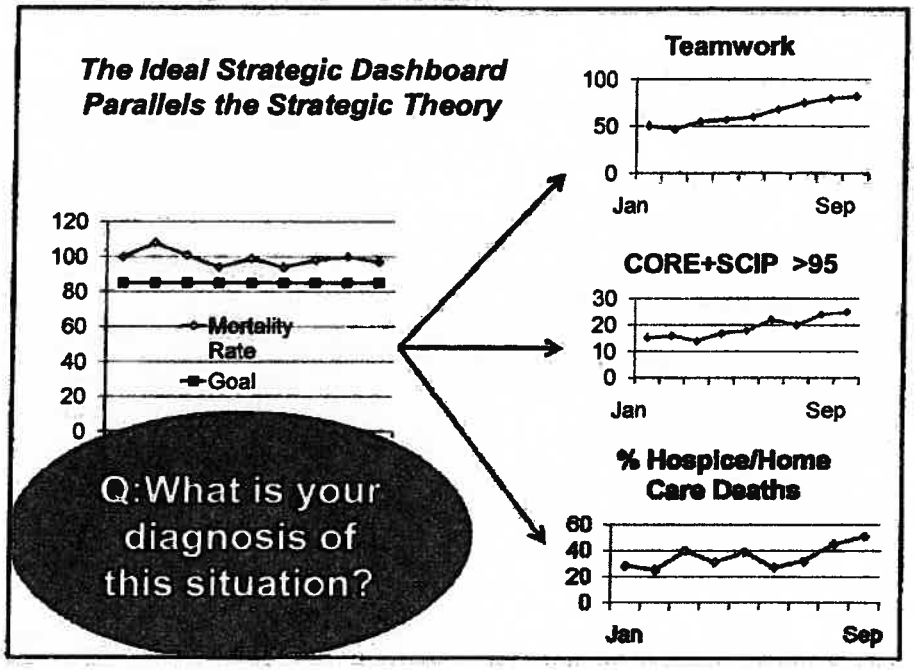
Big Dots (Pillars, BSC…)	Drivers ([illegible])	Projects (Ops Plan)
What are your key strategic aims? How good must we be, by when? What are the system-level measures of those aims?	How, deeply, what really has to be changed, or put in place, in order to achieve each of these goals? What are you tracking to know whether these drivers are changing?	What set of projects will move the drivers far enough, fast enough, to achieve your aims? **How will we know if the projects are being executed?**

Example: A Strategic Theory for the Aim "Reduce Mortality Rate"

Big Dot Aim	Drivers (Core Theory of Strategy)	Projects (Ops Plan)
Reduce mortality rate by 20% in 24 months, as measured by Hospital Standardized Mortality Rate (from 105 to 85)	[illegible] monthly, [illegible] nursing unit. [illegible] evidence-based medicine delivery as measured by [illegible] %. Improved [illegible] deaths in home care or hospice	What set of projects will move the drivers far enough, fast enough, to achieve your aims? **How will we know if the projects are being executed?**


The Ideal Strategic Dashboard
Parallels the Strategic Theory
120
100
80
60
40
20
0
Mortality Rate
Goal
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sept
Teamwork
100
50
0
Jan
Sep
CORE+SCIP >95
20
10
0
Jan
Sep
% Hospice/Home Care Deaths
60
40
20
0
Jan
Sep


The Ideal Strategic Dashboard
Parallels the Strategic Theory
120
100
80
60
Q: Are we on track towards our mortality aim?
A: Maybe, maybe not.
Q: Are we executing our strategy?
A: For End-of-Life Care, and perhaps for Teamwork, Yes! For Evidence-Based Medicine, No!
Teamwork
100
50
0
Jan
Sep
CORE+SCIP >95
20
10
0
Jan
Sep
% Hospice/Home Care Deaths
60
40
20
0
Jan
Sep



It's not enough to have a dashboard that tracks your system-level aims and drivers. If you are to achieve your goals, the board and senior management must review the key data on big dots and drivers, and respond if needed with changes in strategy or improvements in execution, quickly.

Summary: The Strategic Dashboard Answers the Questions...Are We on Track to Achieve Our Aims?...and Is Our Strategy Working?

- To answer these questions...
  - The Board Dashboard should parallel the organization's aims and strategic theory.
  - The measures should be weekly or monthly, real time, and displayed as run charts.
  - Measures do not necessarily need to be risk adjusted, or displayed as rates. You can ***eliminate the denominator*** in many instances.
  - Management and the board should review the key system-level measures at every meeting.

What About the Other Important Type of Quality Question?

- How does our quality measure up...
  - —To other hospitals like ours?
  - —To standards and regulatory requirements?
  - —To industry "benchmarks?"
  - —...etc.

Norton Healthcare's Example

http://www.nortonhealthcare.com/about/qualityreport

Med-Surg ICUs - infections per 1000 device days							
cath-assoc. UTIs	low	1.7	3.4	4.6			3.1
central-line-assoc. BSIs	low	2.0	2.2	1.0			2.2
vent-assoc. pneumonia	low	1.0	2.1	1.4			2.7
Cardiothoracic ICUs - infections per 1000 device days							
cath-assoc. UTIs	low	1.7	3.8				3.7
central-line-assoc. BSIs	low	0.5	0.4				1.6
vent-assoc. pneumonia	low		1.9				5.7
Miscellaneous							
% inpatients with possible infection due to IV lines	low	0.39		0.27		0.18	0.21

Desired Performance
Norton Audubon
Norton Hospital
Norton Suburban
Kosair Children's
Kentucky
U.S.

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What Boards Should Know About Data on

"How Good are We and How do We Compare to Others and/or to Regulatory Standards?"

Upside

- Often risk adjusted
- Apples to apples
- Source of pride
- Source of energy for improvement
- Necessary "staying in business" requirement (licensure, deemed status…)

Downside

- Time lag (months)
- Static (no data over time)
- If you look bad, energy is wasted on "the data must be wrong"
- If you look good, you become complacent
- How you look depends on how others perform
- Standards and benchmarks are full of defects ("The cream of the crap")

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Recommendations for Board Use of "How do We Compare to Others?" Dashboards

1. Don't use comparative reports to oversee and guide improvement at each meeting.
2. Do ask for an "exception report" for any measures that are "off the regulatory and compliance rails."
3. **Create a separate dashboard with all your publicly reported 'compared to others' data and review it annually.**
4. Compare to the best, not the 50th %tile.
5. **Always make sure you know how "green" is determined.**

Summary: Good Board Practices for Dashboards

- **Separate the "comparison" and "strategic" questions into two dashboards.**
- Use the "comparison" dashboard to take stock from time to time, not to steer by.
- Set a **few system-level, specific aims**, and develop a Strategic Dashboard with **timely, "good enough" data** that is based on your theory of what needs to happen to achieve the aims.
- Spend time on your strategic dashboard: If you're not on track to achieve your aims, start asking hard questions.

Oh, and while you're at it....

Put a face on the data

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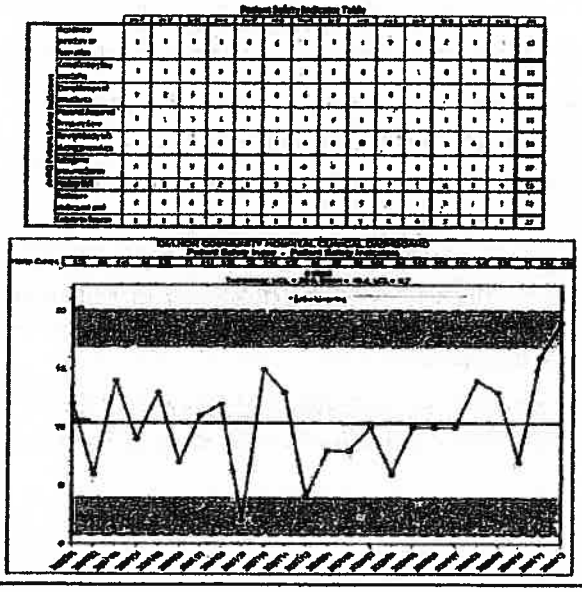
Delnor Dashboard: AHRQ Patient Safety Indicators- One View



Another view of the same data from the previous 6 Months

Deborah A.
8/16/2008
Hosp Acquired Pressure Sore

Jean W.
8/20/2008
Accidental Puncture or Laceration

Frances I.
12/2/2008
Failure to Rescue-Sepsis

George Z.
8/14/2008
Postop DVT

Marie C.
9/18/2008
Reclosure Abd Wall

Michael L.
12/4/2008
Postop DVT

Sandra S.
10/16/2008
Accidental Puncture or Laceration

Harvey S.
12/28/2008
Iatrogenic Pneumonthorax

Sharon Z.
12/20/2008
Accidental Puncture or Laceration

Christine K.
11/20/2008
Accidental Puncture or Laceration

James L.
8/15/2008
Postop DVT

Ruth R.
11/7/2008
Hosp Acquired Pressure Sore

Jeffrey M.
10/29/2008
Failure to Rescue-Shock

Carl E.
11/21/2008
Iatrogenic Pneumonthorax

Helen B.
11/3/2008
Postop DVT

William M.
9/5/2008
Failure to Rescue-GI Hemorrhage

Do you have any opportunities to improve your eyesight?

Oversight: Questions that all Boards should ask, regularly:

- Are we on track to achieve our aim?
- Are we executing our strategy to achieve our aim?
- Are we "off the rails" on any regulatory or compliance issues?
- Does this set of re-credentialing recommendations fully support our mission, aims, and strategies?
- How many patients is that?
- Who is the best in the world?
- Were patients and families involved?

Dashboard Workshop

- Assess your own quality dashboard.
  - Are major aims crystal clear on the dashboard? (how good, by when, as measured by...)
  - Which measures belong on the "how do we compare to others/standards?" dashboard, and which belong on the "Are we on track to achieve our aims?" dashboard?
  - How timely are the measures? How could you improve the time delay in getting feedback on performance?
  - For harm-related measures, does the dashboard answer the question "How many patients was that?
- List three specific improvements you intend to make in your board's quality dashboard.